3 Hospital Service Guidelines

3.1 Introduction

3.1.1 General Policy

This section covers all Medicaid services provided by hospital facilities as deemed appropriate by Medicaid. It addresses the following:

- Claims payment
- Prior authorization
- Inpatient policy
- Outpatient policy
- Administratively Necessary Day (AND)
- Exclusions
- Accommodation revenue codes
- Ancillary revenue codes
- ASC surgical procedures
- Hospital owned and operated ambulance services
- Electronic and paper claims billing

3.1.2 Swing Beds

For those hospitals that meet the Code of Federal Regulation requirements and are approved by Centers for Medicare/Medicaid Services (CMS) to provide swing bed care, a separate provider number is needed for reimbursement from the Medicaid Program. When an application has been approved, the provider will receive a Long Term Care Facility handbook that explains the billing requirements particular to swing beds.

Reimbursement of ancillary services not included in the swing bed rate must be billed on an outpatient claim (bill type 131) and settled on a cost basis with other outpatient services. Prescription drugs must be billed on the outpatient pharmacy claim form.

3.1.3 Payment

Medicaid pays the billed charges multiplied by an outpatient reimbursement rate, except for the following:

- Outpatient laboratory procedures, which are subject to the Medicaid pricing file, are paid at 62 percent of Medicare's prevailing rate.
- Diagnostic radiology services, ambulatory surgical center (ASC) services, and other services paid on a Medicaid fee schedule on an interim basis. For these services, a combination of the fee schedule and actual costs will be determined as payment at cost settlement.

See **Section 1.5** for information on Healthy Connections

Medicaid establishes an upper limit on reimbursement based on Medicare reasonable cost. Payment will not exceed this limit.

Check eligibility to see if the client is enrolled in Healthy Connections, Idaho's Medicaid Primary Care Case Management program. If a client is enrolled,

guidelines must be followed to ensure reimbursement for providing Medicaid-covered services. Inpatient and outpatient services will require a referral from the Healthy Connections primary care provider.

3.1.4 Type of Bill Codes

Enter one of the following codes in Field 4 on the UB92 claim form. Use the code that best describes your claim:

111 Hospital Inpatient (Part A); admit through discharge
112 Hospital Inpatient (Part A); interim-first claim
113 Hospital Inpatient (Part A); interim-continuing claim
114 Hospital Inpatient (Part A); interim-last claim
117 Hospital Inpatient (Part A); replacement of prior claim *(electronic claims only)*
118 Hospital Inpatient (Part A); void/cancel of a prior claim *(electronic claims only)*
121 Hospital Inpatient (Part B); admit through discharge
122 Hospital Inpatient (Part B); interim-first claim
123 Hospital Inpatient (Part B); interim-continuing claim
124 Hospital Inpatient (Part B); interim-last claim
127 Hospital Inpatient (Part B); replacement of prior claim
128 Hospital Inpatient (Part B); void/cancel of a prior claim
131 Hospital Outpatient; admit through discharge
137 Hospital Outpatient; replacement of prior claim
138 Hospital Outpatient; void/cancel of a prior claim
141 Hospital Other (Part B); admit through discharge
151 Hospital Intermediate Care- Level 1; admit through discharge
721 Clinic – Hospital based or Independent Renal Dialysis Center; Admit through discharge (ESRD)
722 Clinic – Hospital based or Independent Renal Dialysis Center; Interim – first claim (ESRD)
723 Clinic – Hospital based or Independent Renal Dialysis Center; Interim – continuing claim (ESRD)
724 Clinic – Hospital based or Independent Renal Dialysis Center; Interim – last claim (ESRD)
831 Hospital ASC Surgery – ASC Services to Hospital Outpatient; admit through discharge
837 Hospital ASC Surgery – ASC Services to Hospital Outpatient; replacement of prior claim
838 Hospital ASC Surgery – ASC Services to Hospital Outpatient; void/cancel of prior claim

3.1.4.1 Type of Bill Codes for Outpatient Medicare Crossovers Only

Use one of the following types of bill codes for outpatient Medicare crossover claims.

135 Hospital Outpatient; Late Charge Only

137 Hospital Outpatient; Replacement of a Prior claim

851 Critical Access Hospital; Admit through discharge

3.1.5 Patient Status Codes

Enter one of the following codes in field 22 on the UB92 claim form.

01	Discharged to home or self care (routine discharge)
02	Discharged/transferred to another short-term general hospital
03	Discharged/transferred to skilled nursing facility (SNF)
04	Discharged/transferred to an intermediate care facility (ICF)
05	Discharged to another type of institution (including distinct part) or referred to another institution
06	Discharged/transferred to home under care of organized home health service organization (Indicate in field 84 the status or location of client and time they left the hospital)
07	Left against medical advice or discontinued care
08	Discharged/transferred to home under care of a home IV drug therapy provider
20	Expired (or did not recover)
30	Still a patient or expected to return for outpatient services
40	Hospice: expired at home
41	Hospice: expired in a medical facility, such as a hospital, SNF, ICF, or freestanding hospice
42	Hospice: expired – place unknown

3.2 Inpatient Hospital Service Policy

3.2.1 Overview

Medicaid pays for inpatient services ordinarily furnished in a hospital for the care and treatment of an inpatient under a physician's direction or, under certain conditions, a dentist.

3.2.2 Inpatient Day

An inpatient day is counted for:

- A patient who is admitted to the hospital for inpatient services, intends to stay overnight, and is in the inpatient bed at the midnight census hour.
- A patient who is admitted for observation in a routine service, has stayed 24 hours, and is not ready to be discharged.

3.2.3 Reimbursement

Medicaid pays billed inpatient charges multiplied by an inpatient reimbursement rate. Medicaid establishes an upper reimbursement limit based on cost audit settlement set by Medicaid. Payment will not exceed this limit.

3.2.4 Accommodation Rates

3.2.4.1 Limitations

Birthing room charges should reflect the normal administrative, nursing, and physical resources utilized for the mother and child occupying the same room. Ancillary services may not be combined with the charge for the accommodation.

Private and psychiatric accommodations will not be reimbursed at more than the semiprivate room rates on file with Medicaid except as stated in **Section 3.2.4.2, Exceptions**.

If the client is placed in a private room for the hospital's convenience Medicaid will pay the semiprivate room rate only. The client must not be billed for the amount in excess of the semiprivate rate.

3.2.4.2 Exceptions

If a client or the family of the client makes an informed choice to incur the additional cost of a private room or luxury accommodations, the hospital may bill the responsible party for the difference between the private and semiprivate room rates.

When the physician writes an order for a private room or isolation for the client because of medical necessity, Medicaid will pay the private room rate. A copy of the statement of medical necessity signed by the physician must be attached to the claim form.

3.2.4.3 Rate Changes

All changes in accommodation rate charges must be submitted to Medicaid on the hospital accommodation rate schedule form in **Section 3.2.8, Hospital Accommodation Rate Schedule**. Please make note of the revenue codes that require an accommodation rate listed in **Section 3.7.2, Accommodation Revenue Codes**.

3.2.5 Mental Health Hospital

Payment for inpatient services provided in a freestanding mental health hospital is limited to hospitals contracted with DHW under the authority of the Division of Family and Community Services serving clients less than twenty-one (21) years of age. Limited outpatient hospital therapy benefits may be provided under revenue codes **914, 915, 916,** and **918**. Inpatient mental health services require prior authorization and must be under the direction of a physician in a facility accredited by the joint Commission on Accreditation of Healthcare Organizations (JCAHO) and licensed by the State of Idaho or the state in which it provides services.

NOTE: All inpatient services and charges for the same revenue code on the same date of service should be combined and billed on the same line of the UB92 claim form or the electronic claim screen.

The Department will pay for medically necessary in-patient psychiatric services for clients under 21 years of age that have a DSM IV diagnosis with substantial impairment in thought, mood, perception or behavior. Both severity of illness and intensity of services criteria must be met for admission.

The Department or its designee must authorize admissions. Admission to an Institute for Mental Disease (IMD) for clients under age twenty-one (21) requires a pre-admission review prior to an elective admission, which is defined as an admission that is planned and scheduled in advance, and is not an emergency in nature.

Emergency admissions require authorization within one workday of the admission. An emergency for purposes of admission is defined as the sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part of the individual, death or harm to the individual, or death or harm to another person.

The hospital medical record of the admission must include documentation to support that the client's status upon admission meets the definition of an emergency as stated above. Requests for authorization of emergency admissions must include the same information as required for elective admissions.

The initial length of stay will be established by the Department or its designee. An individual plan of care must be developed and implemented within seventy-two (72) hours of admission. The plan of care must improve the client's condition to the extent that acute psychiatric care is no longer necessary.

A hospital may request a continued stay review from the Department or its designee, but it must be no later than the date assigned by the Department or its designee. A plan of care must include documentation to support that treatment of the client's psychiatric condition continues to require services that can only be provided on an inpatient basis, including twenty-four (24) hour nursing observation, under the direction of a psychiatrist or other physician qualified to treat mental disease.

Failure to request a pre-admission or continued stay review in a timely manner will result in a retrospective review conducted by the Department or its designee. The Department will assess penalties as defined in **Section 3.2.5.1**.

3.2.5.1 Penalties

Hospital Penalty:

One day late	$260.00
Two days late	$520.00
Three days late	$780.00
Four days late	$1,040.00
Five or more days late	$1,300.00

Physician Penalty for Admitting physician:

One day late	$50.00
Two days late	$100.00
Three days late	$150.00
Four days late	$200.00
Five or more days late	$250.00

3.2.6 Diagnostic Tests and Procedures

Physician-ordered, medically necessary, diagnostic tests and procedures related to the diagnosis and treatment of the client's medical condition(s) are reimbursable. Those tests and procedures include, but are not limited to:

- Laboratory tests
- Pathology tests
- X-ray examinations
- Admission tests

Some procedures may require prior authorization. Refer to *Section 3.4 Prior Authorization* for more information.

3.2.7 Billing Procedures

3.2.7.1 Medicare Crossover Clients

When a client has Medicare coverage, the hospital must bill Medicare first.

Part A and Part B claims should automatically cross over from Medicare to Medicaid. However if this does not happen, you can bill Medicaid electronically with the Medicare information.

When a client has Part A Medicare only, it is not necessary to bill Medicare for Part B services. Bill Medicaid directly for the Part B services and indicate on the paper claim in field 84 of the UB92 that the client has Part A only. Examples of Part B services would include lab work and emergency department services.

See **Section 2.4** for billing instructions on Medicare crossover claims.

3.2.7.2 Birth/Delivery Billing

When submitting a claim for the delivery of a child, the charges for both the mother and the child can be billed on one claim form with the mother's Idaho Medicaid ID number if both leave the hospital at the same time.

If either mother or child remains in the hospital, the claims must be billed separately and the child's services cannot be billed using the mother's ID number. If the child is admitted to the neonatal intensive care unit (NICU)

anytime during the stay, the charges may not be combined with the mother's and must be billed separately. When the mother and child are discharged on the same day, combine all of the charges for like revenue codes.

3.2.7.3 Pregnancy Services

The Pregnant Women and Children (PWC) program is restricted to pregnancy-related services only.

See **Section 1.4.4**, for information on the PWC program.

3.2.7.4 Split Billing

When billing on paper, a client's charges must occasionally be split out and billed on separate claims. Instances when a split billing would occur include:

- Change in client program eligibility
- Inpatient stays that span the hospital fiscal year end
- Portions of an inpatient stay which have been denied by the QIO or Idaho Medicaid
- Inpatient stays that reflect transfers to psychiatric or rehabilitation units assigned a different Medicaid provider number than the general hospital
- Inpatient discharges in which administratively necessary days are billed on an outpatient claim
- Hospital owned and operated ambulance services must be billed on a separate UB92 claim using type of bill 131.

Any inpatient claim submitted with a statement "through date" that is less than the discharge date must have a client status of **30** to indicate that this is an interim billing.

Use MAVIS to verify changes in a client's eligibility. To access MAVIS, use one of these two numbers, depending on your location:

1-208-383-4310 from the Boise calling area, or
1-800-685-3757 outside the Boise calling area

For additional information regarding client eligibility choose option 1. The automated system is available 24 hours a day. Customer service is available Monday through Friday (excluding holidays) from 8 a.m. - 6 p.m. MST.

3.2.7.5 Multiple Rates

When multiple rates exist for the same accommodation revenue code, a separate revenue line should be used to report each rate and the same revenue code should be reported on each line. Failure to split out these multiple rates will result in payment at the lower rate.

3.2.7.6 Donor/Transplants

Donor costs for bone, heart, liver, and kidney transplants should be billed using the client's name and ID number. Enter "donor charges" in the Remarks field of the claim form to prevent a denial of the claim as a duplicate.

3.2.8 Hospital Accommodation Rate Schedule

A copy of the hospital accommodation rate schedule is available in the Forms Appendix or by contacting EDS.

Contact an EDS provider enrollment representative through MAVIS (option 0, option 4) at:

1-208-383-4310 from the Boise calling area, or
1-800-685-3757 outside the Boise calling area

The automated system is available 24 hours a day. Customer service is available Monday through Friday (excluding holidays) from 8 a.m. - 6 p.m. MT.

Return the form to:

EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

Provider Enrollment Fax: (208) 395-2198

3.3 Outpatient Hospital Service Policy

3.3.1 Overview

Outpatient services are services performed in the hospital for a client who does not require inpatient accommodations. The items or services must be medically necessary and performed by or under the direction of a physician or, under certain circumstances, a dentist.

Outpatient services are to be provided at a service location over which the hospital exercises financial and administrative control. *"Financial and administrative control"* means a location whose relation to budgeting, cost reporting, staffing, policy-making, record keeping, business licensure, goodwill, and decision-making are so interrelated to those of the hospital that the hospital has ultimate financial and administrative control over the service location. The service location shall be in close proximity to the hospital where it is based, and both facilities serve the same patient population (e.g. from the same area, or catchment within Medicare's defined Metropolitan Statistical Area (MSA) for urban hospitals or thirty-five (35) miles from a rural hospital).

NOTE:
All similar revenue codes with the same dates of service, with the exception of revenue codes requiring CPT procedure codes, should be billed on one line of the outpatient claim form or the electronic claims screen.

Outpatient services can include the following:

- Preventative
- Diagnostic*
- Admission tests
- Therapeutic
- Rehabilitative
- Palliative
- Laboratory [PA]
- Pathological [PA]

[PA] Some services require prior authorization by the Department. Refer to *Section 3.4 Prior Authorization* for more information.

The following revenue codes require the appropriate CPT or HCPCS procedure code and modifier combinations:

300 – 309	**561**	**831**
320 – 324	**569**	**841**
340 – 341	**610 – 618**	**851**
350 – 352	**634 – 636**	**924**
400 – 404	**657**	**942**
550	**771**	
559	**821**	

Note: Radiology services must include the TC modifier.

3.3.2 Reimbursement

Medicaid pays the covered charges multiplied by an outpatient reimbursement rate, except for the following:

- Outpatient laboratory procedures, which are subject to the Medicaid pricing file, are paid at 62 percent of Medicare's prevailing rate.

- Diagnostic radiology services, ambulatory surgical center (ASC) services, and other services are paid at the Medicaid fee schedule rate on an interim basis. For these services, a combination of the fee schedule and actual costs will determine a blended rate for payment at cost settlement.

Medicaid establishes an upper limit on reimbursement based on Medicare reasonable cost. Payment will not exceed this limit.

3.3.3 Outpatient Observation

Observation should be billed under the revenue code that reflects the service area in which the provider accounts for the client and the related costs (inpatient room, outpatient room or emergency room).

When a client is observed in an inpatient bed by staff assigned to the routine care area, revenue code **073** should be used to reflect the costs of the routine service area. Any client, who is in observation status in a routine service area after 24 hours, must be admitted at the beginning of the 25th hour.

Observation in a designated room or not in an inpatient bed should be billed under revenue code **760**.

Observation room and time may not be billed as a substitute for an emergency department visit or nursing services rendered outside the emergency department.

Observation time cannot be substituted for stays denied by the QIO when the intensity of services does not justify an inpatient day.

3.3.4 Professional Component

Medicaid has an arrangement with Medicare for the automatic billing by magnetic tape of additional coverage amounts for shared Medicare Part B/Medicaid clients. Hospital services related to the professional component of all ancillary services that are submitted to Medicare are automatically submitted, processed, and forwarded to Medicaid.

See **Section 2.4** for information on Crossover Claims.

3.3.5 Presumptive Eligibility and PWC Clinic

Presumptively eligible clients are only eligible for outpatient pregnancy-related services. Some Hospitals and District Health Departments are PWC (Pregnant Women & Children) Clinics. They must be a Medicaid approved provider and meet the conditions for presumptive eligibility of pregnant women. Additionally, approved providers must be trained and certified by the Department. For more information on the training process, please contact your local Department of Health and Welfare eligibility office.

See **Section 1.4.1** for information on Presumptive Eligibility.

3.3.6 Physical Therapy Limitations

Physical therapy visits are limited to 25 visits per calendar year regardless of the billing provider. If additional medically necessary visits are required, prior authorization must be obtained from:

Bureau of Care Management
Physical Therapy Authorizations
P.O. Box 83720
Boise, ID 83720-0036

Fax number (208) 364-1864

3.3.7 Emergency Department (ED) Limitations

Payment for emergency department (ED) visits is limited to six (6) per calendar year. Emergent or urgent visits billed only as outpatient observation room (revenue codes **76X**), general outpatient services (**50X**), or clinic

services (**51X**), may count toward the total six visits yearly. Count the ED visit as one unit unless the client is seen twice on the same day.

ED visits that are followed by an immediate admission to inpatient status should be billed as part of the inpatient service and will be excluded from the six-visit limit.

When total ED visits are exhausted, all other Medicaid covered charges on the claim form are still reimbursable.

3.3.8 Healthy Connections

Services performed in an ED do not require a Healthy Connections referral. Services billed on an Institutional claim with revenue code 450 and services billed on a Professional claim (with POS 23) are exempt from the Healthy Connections referral requirement.

3.3.9 Billing Procedures

See **Section 2.3** for information on Crossover Claims.

3.3.9.1 Medicare Crossover Clients

Medicare claims will automatically cross over from Medicare to Medicaid. However, if the claim does not automatically cross over, a copy of the Medicare Remittance Notice (MRN) must be attached to the claim form before submission to Medicaid. Providers can also submit electronic cross over claims using PES.

3.3.9.2 Third Party Recovery

See **Section 2.3, Third Party Recovery**, regarding Medicaid policy on billing all other third party resources before submitting claims to Medicaid.

3.3.9.3 Oral Surgeons

Oral Surgeons who perform services in the hospital setting are required to bill CPT surgical codes on the Professional claim form using their physician provider number. Do not use CPT procedure code 41899 (unspecified code); it will cause a delay in payment for services. Extractions must be billed on an American Dental Association (ADA) claim form under the dental provider number, with the appropriate CDT dental code and tooth number. Do not bill on a Professional claim form for extractions.

3.4 Prior Authorization

3.4.1 Overview

The Idaho Medicaid program has contracted with Qualis Health (formerly PRO-West), a quality improvement organization (QIO), to conduct the medical and surgical reviews of inpatient and selected outpatient hospital services. The appropriateness and necessity of the client's admission and length of stay are subject to QIO review.

See **Sections 3.4.12 and 3.4.13** for a listing of the surgical procedures and diagnosis codes that require prior authorization (PA). Refer to the *Qualis Health Provider Manual* for details regarding review procedures.

The attending physician is ultimately responsible for obtaining preadmission approval (except for emergencies). However, the QIO will accept preadmission monitoring calls from the surgeon, physician office personnel, or facility personnel when applicable. Healthy Connections clients require a referral from their primary care provider for all inpatient and outpatient hospital services in addition to the QIO prior authorization.

When billing, if prior authorization is required, the prior authorization number must be indicated on the claim. Enter the PA number in Field 63 on the UB92 claim form. For electronic claims, enter the PA number in the prior authorization field on the screen. Prior authorizations are valid for one year from the date of authorization by Medicaid unless otherwise indicated on the approval. For Healthy Connections clients, prior authorization will be denied if the requesting provider is not the primary care provider or a referral has not been obtained.

See **Section 1.7.7** for information on Prior Authorization.

See **Section 3.4.2** for information on authorization for emergency services.

3.4.2 Admitting and Principal Diagnoses

It is very important to include the admitting diagnosis code and the principal diagnosis code on the UB92 claim. These codes are used to determine if the admission requires QIO review.

If the admitting diagnosis and the discharge (principal) diagnosis are different, and one of them is a condition that does require pre-admission review, then the admission requires QIO pre-admission review.

3.4.3 Length of Stay Review

Concurrent review is required when the admission exceeds day three (3), or the number of days assigned by the QIO for a procedure. In the event the admitting diagnosis is different from the principal diagnosis, the diagnosis that allows the greatest length of stay is used to determine the length of stay for the admission. When QIO approval has been given for a portion of the hospital stay, accommodation days are payable only to the QIO scheduled discharge date or the last approved day.

> ***Example**:* If the discharge date is 08/15/2004 and QIO approved discharge is 08/14/2004, the last accommodation day to be covered by Medicaid would be 08/13/2004.
>
> Although the room charge is not covered for 08/14/2004, the ancillary charges can be submitted with the stay. Medicaid would **not** pay the accommodation or ancillaries for 08/15/2004.

3.4.4 Transfers

QIO authorization is not required for transfers from hospital to hospital inpatient status (inter-facility).

Authorization is required for transfers into psychiatric, substance abuse, or rehabilitation units within the same hospital (intra-facility). The receiving unit is responsible for obtaining the authorization within one working day of the transfer. The sending unit is not required to obtain a transfer review.

3.4.5 Out-of-State Providers

All medical care provided outside the state of Idaho is subject to the same prior authorization and continued stay review requirements and restrictions as medical care provided within Idaho. See Section 3.4.12 and 3.4.13 for a list of diagnoses and procedures requiring prior authorization review. If prior authorization is required, the prior authorization number must be indicated on the claim or that service will be denied.

The client's physician(s) or the treating facility may initiate the request for prior authorization. The treating physician(s) and the treating facility are equally responsible for obtaining prior authorization.

The Medicaid Transportation Unit (MTU) must prior authorize non-emergent transportation for out-of-state care. Providers may contact MTU at (800) 296-0509 or (208) 334-4990. Fax (800) 296-0513.

3.4.6 Admission for Substance Abuse

With implementation of OBRA 90, Medicaid coverage of substance abuse includes certain inpatient detoxification and rehabilitation services. QIO approval is required for inpatient services under either the psychiatric/chemical dependency admissions category (diagnosis codes **291-314**) or the rehabilitation admissions category (diagnosis code **V57**).

3.4.7 Cesarean Section

Effective for dates of service on or after September 1, 2003, when billing for a C-section, use the appropriate diagnosis code indicating the reason for the C-section. The following range of diagnoses in the table below will have a four(4) day length of stay and will require a review with the Department's Quality Improvement Organization (QIO), Qualis Health, if the patient is not discharged after the fourth day. Diagnosis codes 669-70 and 669.71 will no longer be reimbursed when reported as the admitting or primary diagnosis.

Contact Qualis Health toll-free at (800) 783-9207 for a telephonic review or fax your request to (800) 826-3836.

Diagnosis Code (Code to the 5th digit 642.5—663.4)	Description
642.5 *(0,1,2,4)*	Severe pre-eclampsia
652.2—652.8 *(0,1,3)*	Apposition and malpresentation of fetus
653.4 *(0,1,3)*	Fetopelvic disproportion
654.2 *(0,1,3)*	Abnormality of organs and soft tissues of pelvis, previous cesarean delivery
659.7 *(0,1,3)*	Abnormality in fetal heart rate or rhythm
660.0—660.8 *(0,1,3)*	Obstructed labor
661.00—661.43	Abnormality of forces of labor

Diagnosis Code (Code to the 5th digit 642.5—663.4)	Description
663.1 *(0,1,3)*	Umbilical cord around neck, with compression
663.4 *(0,1,3)*	Umbilical cord complications, short cord
763.4	Fetus or newborn affected by other complication of labor and delivery, cesarean delivery
V30.01	Single liveborn, born in a hospital, delivered by cesarean delivery
V31.01	Twin, mate liveborn, born in a hospital, delivered by cesarean delivery
V32.01	Twin, mate stillborn, born in a hospital, delivered by cesarean delivery
V33.01	Twin, unspecified, born in a hospital, delivered by cesarean delivery
V34.01	Other multiple, mates all liveborn, born in a hospital, delivered by cesarean delivery
V35.01	Other multiple, mates all stillborn, born in a hospital, delivered by cesarean delivery
V36.01	Other multiple, mates live- and stillborn, born in a hospital, delivered by cesarean delivery
V37.01	Other multiple, unspecified, born in a hospital, delivered by cesarean delivery

3.4.8 Medicaid/Medicare Eligibility

Some Medicare clients have both Medicare and Medicaid coverage for hospitalizations. For those clients with Part A Medicare (inpatient services), QIO review is not necessary if Medicare is the primary payer. Medicare guidelines should be followed. If, however, the client has only Part B Medicare (outpatient services), the admission is subject to QIO review because Medicaid is the primary payer for the inpatient services. Verify eligibility through MAVIS. To access MAVIS, use one of these two numbers, depending on your location:

For additional information regarding third party coverage, contact MAVIS at:

(208) 383-4310 from the Boise calling area, or
(800) 685-3757 outside the Boise calling area

The automated system is available 24 hours a day. Customer service is available Monday through Friday (excluding holidays) from 8 a.m. - 6 p.m. MST.

3.4.9 Other Insurance

When the client has other insurance, QIO authorization is required, although the other insurance must be billed prior to Medicaid. Use MAVIS to verify other insurance coverage.

3.4.10 Retrospective/Late QIO Reviews

Retrospective review is a review of cases for clients who were not eligible at the time of the admission but who were determined eligible at a later date. In these cases, Medicaid will not assess penalties to the provider.

Late review is a review of cases where the client was eligible and prior authorization was not obtained prior to the hospital admission. Qualis Health

accepts telephonic requests for late reviews only if the client is still in the hospital at the time Qualis Health is notified. If the client has already been discharged, providers must submit a Retrospective Review Request Form to Qualis Health with a copy of the history and physical, discharge summary, completed UB92 claim, and operative report (if applicable). Refer to the Qualis Health Provider Manual, Exhibit 15 for a copy of the Request Form and additional instructions.

Medicaid may assess a penalty if a hospital does not secure a QIO review in a timely manner. These penalties are based on how late the review is made, as follows:

- One day late = $260. 00
- Two days late = $520. 00
- Three days late = $780. 00
- Four days late = $1,040. 00
- Five days late = $1,300. 00

Mail all Medicaid correspondence regarding QIO issues to:

Idaho Medicaid
Bureau of Operations
Contracts Unit
P.O. Box 83720
Boise, ID 83720-0036

Or call: **(208) 287-1177**
Monday through Friday (excluding holidays)
8 a.m. - 5 p.m. MT

3.4.11 Contacting Qualis Health

Qualis Health
PO Box 33400
Seattle, WA 98133-9075

To reach Qualis Health, call (**800) 783-9207**, press 122. Fax number (800) 826-3836. Monday-Friday between 7:30 a.m. and 6:45 p.m. (MST). Voice mail is available 24 hours a day, seven days a week. To access Qualis Health via the internet: **www.qualishealth.org/medicaid.htm**

3.4.12 Inpatient and Outpatient Psychiatric and Rehabilitation Diagnoses Requiring Prior Authorization

Inpatient and outpatient procedures that require QIO prior authorization include the following codes, when performed on Idaho Medicaid clients and children in the legal custody or legal guardianship of the State of Idaho, Division of Family and Children Services:

Inpatient Psychiatric or Chemical Dependency Admissions (use fourth or fifth digit subclassification): **291.0 through 314.0**
Inpatient Physical Rehabilitation Admissions: **V57** ***NOTE:*** This includes admission to all rehabilitation hospitals, regardless of the diagnosis on the claim.

3.4.13 Inpatient and Outpatient Procedures Requiring QIO Prior Authorization

QIO prior authorization is also required for all elective or scheduled admissions when the client is admitted one or more days prior to a planned surgery that is on the following list. QIO review is required for all surgeries on the list, whether inpatient or outpatient.

Procedure	ICD-9-CM Code	CPT Code
Arthrodesis	78.59 81.00 through 81.08 81.30 through 81.39 81.61 81.62, 81.63, 81.64	**22532, 22533, 22534 (effective 04/01/04)** 22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280
Unlisted neck, thorax procedure **Unlisted spine procedure**	**78.41 (effective 4/1/04)** **78.71 (effective 4/1/04)**	**21899 (effective 04/01/04)** **22899 (effective 04/01/04)**
Hysterectomy	68.31, 68.39	58180, 59135, 59525
Abdominal	68.4 68.6	58150, 58152, 58200, 58951, 59135, 59525 58210
Vaginal	68.51 68.59	58550, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 58290, 58291, 58292, 58293, 58294
Laparoscopic		
Radical	68.7	58953, 58954
Other and Unspecified	68.9	

Procedure	ICD-9-CM Code	CPT Code
Laminectomy/Diskectomy	03.02 03.09 03.1 03.6 80.50 80.51	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200
Reduction Mammoplasty Unilateral, Bilateral	85.31, 85.32	19318
Total Hip Replacement	81.51	27130
Total Hip Revision	81.53	27132, 27134, 27137, 27138
Partial Hip Replacement	81.52	27125
Total Knee Replacement	81.54	27445, 27446, 27447
Total Knee Revision	81.55	27486, 27487
Transplants		
Transplant facilities must be Medicare approved		
Bone Marrow Transplant Autologous	41.00, 41.01, 41.04, 41.07, 41.09	38241
Bone Marrow Transplant Allogenic	41.02, 41.03, 41.05, 41.06, 41.08	38240, 38242
Liver Transplant	50.59	47135, 47136
Kidney Transplant	55.61 55.69	50380 50360, 50365
Intestinal Transplant	46.97	44133, 44135, 44136
Heart Transplant	37.51, 37.52, 37.53, 37.54	33945
Note: all bariatric procedures require prior authorization by the Department. See section 3.4.14 for more information		
Alcohol and Drug Rehabilitation and Detoxification		
Inpatient Only		
Alcohol Rehabilitation	94.61	90899
Alcohol Detoxification	94.62	90899
Alcohol Rehabilitation and Detoxification	94.63	90899
Drug Rehabilitation	94.64	90899
Drug Detoxification	94.65	90899
Drug Rehabilitation and Detoxification	94.66	90899
Combined Alcohol and Drug Rehabilitation	94.67	90899
Combined Alcohol and Drug Detoxification	94.68	90899
Combined Alcohol and Drug Rehabilitation and Detoxification	94.69	90899
Psychiatric Admissions		
Diagnosis codes	291.0 through 314.0	Inpatient only

Procedure	ICD-9-CM Code	CPT Code
Physical Rehabilitation		
Care involving use of rehabilitation procedures. This includes admission to all rehabilitation facilities, regardless of diagnosis.	V57 (Diagnosis Code)	Inpatient only

3.4.14 Inpatient/Outpatient Prior Authorization by Medicaid

Medicaid prior authorization is required for the following procedures:

- Reconstructive surgery not on the Qualis Health list
- Plastic surgery not on the Qualis Health list
- Cosmetic surgery not on the Qualis Health list
- Elective surgery not on the Qualis Health list
- All bariatric procedures
- Administratively Necessary (AND) days
- Excluded services found medically necessary in an EPSDT screen
- Physical therapy visits that exceed 25 visits per calendar year
- PET scans (Positron Emission Tomography) *See Section 3.4.15.1 for more information.*
- Genetic Pathology and Laboratory Testing

Refer to Section 3.4.15 for the listing of medical and surgical procedure codes that require prior authorization from Medicaid.

Healthy Connections clients require a referral from their primary care provider for all inpatient and outpatient hospital services in addition to a Medicaid or Qualis Health prior authorization.

Send Prior Authorization requests to:

Idaho Medicaid
Care Management Authorizations
P.O. Box 83720
Boise, ID 83720-0036

Fax: (208) 364-1864

When billing, if prior authorization is required, the prior authorization number must be reported on the claim.

3.4.15 Medical Surgical Procedures Requiring Medicaid Prior-Authorization

Proc	Description
03.29	Other chordotomy
15831	Excessive skin and subcutaneous tissue; abdomen
15877	Suction assisted lipectomy; trunk
17106	Destruction of cutaneous vascular proliferative lesions; less than 10 sq cm
17107	Destruction of cutaneous vascular proliferative lesions; 10.0 - 50.0 sq cm
17108	Destruction of cutaneous vascular proliferative lesions; over 50.0 sq cm
19324	Mammoplasty, augmentation w/o prosthetic implant
19325	Mammoplasty with prosthetic implant
19328	Removal of intact mammary implant
19330	Removal, breast implant
19340	Immediate insertion of breast prosthesis
19342	Delayed insertion of breast prosthesis
19350	Reconstruction, nipple/areola
19357	Breast reconstruct w/tissue expander include subsequent expansion
19361	Breast reconstruct w/latissimus dorsi flap, w/wo prosthetic implant
19364	Breast reconstruction with free flap
19366 through 19371	Breast reconstruction
19380	Revision of reconstructed breast
19499	Unlisted procedure, breast
29999	Unlisted procedure, arthroscopy
30462	Rhinoplasty; tip, septum, osteotomies
36521	Therapeutic apheresis; with adsorption and plasma reinfusion
37700	Ligation & division of long saphenous vein at saphenofemoral junction
37720	Ligation, division & complete stripping of long or short saphenous veins
37730	Ligation, division & complete stripping of long and short saphenous veins
37735	Ligation, division & complete stripping of long or short saphenous
37760	Ligation of perforator veins, subfascial, radical
37780	Ligation & division of short saphenous vein
37785	Ligation, division and/or excision of recurrent or secondary varicose veins
38.59	Leg varicose veins ligation & stripping
43659	Laparoscopy, unlisted stomach procedure
43842	Gastric restrictive procedure-Medicare xover only
43843	Gastroplasty, other than vert-banded, w/o bypass
43846	Gastric bypass, with roux-en-y gastroenterostomy
43847	Gastric procedure; w/bowel reconstruction
43850	Revision of gastroduodenal anastomosis w/reconstruct
44.31	High gastric bypass
44.39	Gastroenterostomy nec
48160	Pancreatectomy
50.51	Auxiliary liver transplant, leaving patients own liver in situ
52640	Resection, prostate
59866	Multifetal pregnancy reduction(s)
61885	Incision subcutaneous place cranial neurostimulator
64573	Incision for implant of neuro electrodes, cranial nerve
69930	Cochlear device implant; w/wo mastoidectomy

Proc	Description
74799	Unlisted pulmonary procedure
85.53	Unilateral breast implant
85.54	Bilateral breast implant
85.7	Total breast reconstruct
85.83	Breast full-thick graft
85.84	Breast pedicle graft
85.85	Breast muscle flap graft
85.87	Nipple repair nec
85.93	Breast implant revision
85.94	Breast implant removal
85.95	Insert breast tissue expander
85.96	Remove breast tissue expander
85.99	Breast operation nec
86.83	Size reduction plastic op, liposuction
87903	Phenotype analysis by DNA/RNA, HIV 1, first through 10 drugs tested
87904	Phenotype analysis by DNA/RNA, HIV1, each additional 1 through 5 drugs
88235	Tissue culture for chromosome analysis, amniotic
88267	Chromosome analysis, amniotic fluid
88280	Chromosome analysis, amniotic fluid
88289	Chromosome analysis; additional high resolution study
97039	Unlisted modality; constant attendance
97139	Physical medicine treatment unlisted procedure
97799	Unlisted physical medicine service or procedure
99.99	Non-op procedure nec
	Positron Emission Tomography (PET) G0030-G0047; G0125; G0210-G0230; G0252-G0254; G0296

3.4.15.1 PET Scan (Positron Emission Tomography)

PET scans require authorization from the Bureau of Care Management prior to services being rendered. For questions regarding prior authorizations, please call (208) 364-1824. A copy of the PA intake form can be found in the Appendix for Forms. Prior Authorization requests must be faxed to (208) 364-1864 or mailed to:

Idaho Medicaid
Bureau of Care Management
P.O. Box 83720
Boise, ID 83720-0036

When billing for a PET Scan, bill with revenue code 404, the authorized HCPCS code, modifier TC, and the prior authorization number.

3.4.16 Attachments

Inpatient attachments include the following:

- TPR — when billing on a paper claim form, attach the EOB statement from the other insurer that includes the adjustment reason codes (ARC). When billing electronically, use the appropriate the ARC codes from the other insurer; no attachment is required.

- Hysterectomies — authorization for hysterectomy and documentation of medical necessity
- Sterilizations — appropriately completed consent form
- Therapeutic abortions — completed Certification of Necessity
- Private room — statement of medical necessity or physician order

Outpatient attachments include:

- TPR — when billing on a paper claim form, attach the EOB statement from the other insurer that includes the adjustment reason codes (ARC). When billing electronically, use the appropriate the ARC codes from the other insurer; no attachment is required.
- Sterilization — appropriately completed consent form

3.4.17 Hospital Physicians

Hospital-based physician billers should refer to the *Idaho Medicaid Provider Handbook* for Physicians/Osteopaths to submit professional claims.

3.5 Administratively Necessary Day (AND)

3.5.1 Overview

An Administratively Necessary Day (AND) is intended to allow a hospital the time for an orderly transfer or discharge of recipient inpatients who are no longer in need of a continued acute level of care. ANDs may be authorized for inpatient recipients who are awaiting placement in a skilled nursing facility (SNF) or intermediate care facility (ICF/MR), or in-home services which are not available, or when catastrophic events prevent the scheduled discharge of an inpatient.

3.5.2 Prior Authorization

The hospital discharge planner, utilization reviewer, or attending physician must contact the Department of Health and Welfare's Medicaid Bureau of Care Management by phone or fax to request an AND. The AND Intake Form must be submitted to the Bureau of Care Management **prior** to acute hospital discharge. This can be done as soon as the discharge planner anticipates a possible discharge issue, even before the final non-cerfified date is known. The facility must supply the additional required documentation within 10 working days of the submitted request. If the AN Days are not necessary, due to a reversal of the possible non-certification, immediately notify the Care Management Bureau, at the number below, and the request will be voided. When billing the AND, the prior authorization number must be indicated on the claim.

FORM AVAILABLE: The AND Intake Form is included in the Forms Appendix of this handbook.

To request an AND, fax the AND Intake Form and required documentation to **(208) 364-1864**.

For questions, call (**208) 364-1824** Monday through Friday (excluding holidays) from 8 a.m. – 5 p.m. MST

The following documentation is required for prior authorization of an AND:

- AND Intake Form
- Summary of patient's medical condition
- Current history and physical
- Physician progress notes
- Statement as to why patient cannot receive necessary medical services in a non-hospital setting
- Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services

3.5.3 Retroactive Eligibility

Services provided to an individual will be deemed prior approved if the individual was not eligible for Medicaid at the time the service was provided, but was subsequently found eligible. The service provided is approved by the Department with the same guidelines and documentation requirements as other prior authorization requests for AND.

3.5.4 Notice of Decision

The Department will review each prior authorization request and issue a decision and prior authorization number, which is faxed to the requesting provider. The Department will also issue a Notice of Decision letter for each prior authorization request, which is mailed to the client and the requesting provider.

3.5.4.1 Limitations

Each recipient is limited to no more than three (3) ANDs per discharge. There is no limit to the number of ANDs allowed per year.

3.5.5 Billing Procedures

AND services must be billed on the Institutional claim form as an outpatient service. The first AND should be the same day the client was discharged from the inpatient acute level of care. The AND authorization number must be in the prior authorization field of the claim.

The hospital should utilize the same billing procedure as is currently used for outpatient claims with the following exceptions when billing for an 'AN' day:

- Type of Bill (Field 4) use code 151
- Revenue Codes (Field 42)
- Supplies and ancillary charges (except those listed in **Section 3.5.6, Revenue Codes**) are part of the content of care.

3.5.6 Revenue Codes

Listed below are the only revenue codes that can be billed with an Administratively Necessary Day (AND).

CPT	Must list valid CPT laboratory procedure code.
QIO	Authorization must be attached.
HOSP	The ambulance must be owned and operated by the hospital
HCPCS	Must list valid HCPCS code

280 — Oncology General
289 — Oncology Other
300 — Laboratory CPT
301 — Chemistry CPT
302 — Immunology CPT
303 — Renal Client (Home) CPT
304 — Non-routine Dialysis CPT
305 — Hematology CPT
306 — Bacteriology/Microbiology CPT
307 — Urology CPT
310 — Lab Pathology
311 — Cytology
312 — Histology
314 — Biopsy
320 — Radiology-Diagnostics CPT
321 — Angiocardiography CPT
322 — Arthrography CPT
323 — Arteriography CPT
324 — Chest X-ray CPT
330 — Radiology Therapy
331 — Chemotherapy Injected
332 — Chemotherapy Oral
333 — Radiation Therapy
335 — Chemotherapy IV
340 — Nuclear Medicine CPT
341 — Diagnostic CPT
342 — Therapeutic – oral
350 — CAT Scan CPT
351 — Head Scan CPT
352 — Body Scan CPT
380 — Blood Services
381 — Packed Red Cells
382 — Whole Blood Cells
383 — Plasma
384 — Platelet
385 — Leukocytes

386 — Other Components
387 — Other Derivatives (Cryopricipitates)
390 — Blood Storage and Processing
391 — Blood Administration
400 — Other Imaging Services CPT
401 — Diagnostic Mammography CPT
402 — Ultrasound CPT
403 — Screening Mammography CPT
404 — Positron Emission Tomography(PET) HCPCS
410 — Respiratory Services
460 — Pulmonary Function
470 — Audiology
471 — Diagnostic
472 — Treatment
480 — Cardiology
481 — Cardiac Catheterization Lab
482 — Stress Test
489 — Other Cardiology
540 — Ground Ambulance; Non-emergency
541 — Ambulance Supplies
542 — Ground Ambulance; Emergency
544 — Ambulance Oxygen
545 — Air Ambulance – all levels of Life Support
546 — Ground or Air Ambulance –Neonatal Services
547 — Ambulance Pharmacy
549 — Ambulance EKG Services
610 — MRI-Trunk and extensions CPT
611 — MRI-Brain & Brainstem CPT
612 — MRI-Spine & Spinal Cord CPT
671 — Outpatient Special Residence Charges – Hospital Based—Administravely Necessary Day
730 — EKG/ECG
731 — Holter Monitor
732 — Telemetry (Including Fetal Monitor)
740 — EEG
750 — Gastro-Intestinal
790 — Lithotripsy
811 — Living Donor-Kidney QIO
812 — Cadaver Donor-Kidney QIO
813 — Unknown Donor-Kidney QIO
819 — Other Organ Acquisition QIO
820 — Hemodialysis; Outpatient or Home
821 — Hemodialysis/Composite or other Rate CPT
830 — Peritoneal Dialysis
831 — Peritoneal Composite CPT
840 — CAPD, Outpatient or Home
841 — CAPD Composite or other Rate CPT
850 — CCPD Outpatient or Home
851 — CCPD Composite or other Rate CPT
880 — Miscellaneous Dialysis
881 — Ultrafiltration
889 — Other Miscellaneous Dialysis
921 — Peripheral Vascular Lab
922 — EMG
923 — Pap Smear
924 — Allergy Test CPT
925 — Pregnancy Test
946 — Air Fluidized Bed
947 — Other Therapeutic Complex Medical Equipment

3.6 Coverage Limits

3.6.1 Excluded Services

Services excluded from Medicaid coverage include the following:

- Acupuncture services
- Biofeedback therapy
- Laetrile therapy
- Eye exercise therapy
- Surgical procedures on the cornea for myopia
- Cosmetic surgery; excluding reconstructive surgery which has prior approval by the Department.
- Elective medical and/or surgical treatment, except for family planning services, without Departmental approval.
- Vitamin injections in the doctor or other licensed prescriber's office that are not needed for a specific diagnosis
- Organ transplants; lung, pancreas, or other transplant considered investigative or experimental, multiple organ transplants
- New procedures of unproven value and established procedures of questionable current usefulness as identified by the Public Health Service, and which are excluded by the Medicare program are also excluded from Medicaid payment.
- Treatment of complications, consequences or repair of any medical procedure, in which the original procedure was excluded from Medicaid coverage, unless the resultant condition is deemed life threatening as determined by Medicaid.
- Routine physical examinations for adults or examinations in connection with the attendance, participation, enrollment, or accomplishment of a program or for employment.
- Procedures and testing for the inducement of fertility. This includes, but is not limited to, artificial insemination, consultations, counseling, office exams, tuboplasties, and vasovasotomies.
- Naturopathic services
- Abortions except when the mother's life is in jeopardy or in cases of rape or incest.

3.6.2 Restricted Procedures

3.6.2.1 Physical Therapy

Physical therapy visits that exceed 25 visits per calendar year require prior authorization from the Bureau of Care Management. See **Section 3.3.6** for additional information.

3.6.2.2 Cosmetic Surgery

All cosmetic surgery must be medically necessary and have Medicaid prior authorization.

3.6.2.3 Obesity

Surgery for the correction of obesity is covered only with prior authorization from the Bureau of Care Management. Surgical procedures for weight loss will be considered when the client meets the criteria for morbid obesity as defined in the Rules Governing Medical Assistance, IDAPA 03.09.003.38. The client must also have one of the major life threatening complications of obesity:

- alveolar hypoventilation
- uncontrolled diabetes
- uncontrolled hypertension

For purposes of this subsection, "uncontrolled" means that there is inadequate compliance or response to a prescribed medical regimen. Other complications of obesity such as orthopedic treatment, skin and wound care are not considered justification for a surgical remedy.

Clients must have a psychiatric evaluation to determine the stability of personality at least three months prior to the date the surgery is requested. The client must understand and accept the resulting risks associated with the surgery.

All clients requesting surgery must have their physician send a complete history and physical exam, and medical records documenting the client's weight and efforts to lose weight by conventional means over the past five years for the request to be considered.

The documentation of life threatening complications per IDAPA 03.09.069.01.c. must be provided by a consultant specializing in pulmonary diseases, endocrinology, or cardiology and hypertensive illness. The consultant cannot be associated by clinic or other affiliation with the surgeons who will perform the surgery or with the primary physician who refers the client for the procedure.

Abdominoplasty or panniculectomy is covered only with prior authorization from the Bureau of Care Management. Medicaid does not cover procedures for cosmetic purposes. The documentation that must accompany a request for prior authorization includes, but is not limited to, all of the following:

- Photographs of the front, side and underside of the client's abdomen
- Documented treatment of the ulceration and skin infections involving the panniculus
- Documented failure of conservative treatment, including weight loss
- Documentation that the panniculus severely inhibits the client's walking
- Documentation that the client is unable to wear a garment to hold the panniculus up
- Documentation of other detrimental effects of the panniculus on the client's health such as severe arthritis in the lower body.

3.6.2.4 Transplants

The Department may purchase organ transplant services for bone marrow, kidneys, hearts, intestines, and livers when provided by hospitals approved by the Centers for Medicare and Medicaid Services (CMS) for the Medicare program and that have completed a provider agreement with the Department. The Department may purchase cornea transplants for condition where such transplants have demonstrated efficacy. Transplants, except for cornea transplants, must be prior authorized by the QIO

Hospitals should obtain and use a separate provider number from Idaho Medicaid for transplants. This allows the hospital to accurately receive the lesser of 96.5% of Reasonable Costs under Medicare payment principals or Customary Charges.

The transplant costs for actual or potential living kidney donors are fully covered by Medicaid and include all reasonable preparatory, operation, and post-operation recovery expenses associated with the donation. Payments for post-operation expenses of a donor will be limited to the period of actual recovery.

Follow-up care provided to an organ transplant patient by a provider not approved for organ transplants will be reimbursed at the provider's normal reimbursement rates. Reimbursement to Independent Organ Procurement Agencies and Independent Histocompatibility Laboratories will **not** be covered.

Multi-organ transplants such as heart/lung or kidney/pancreas and the transplant of artificial hearts or ventricular assist devices are not covered.

Refer to *IDAPA 16.03.09.081 Organ Transplants* for additional information.

3.6.2.5 Fertility

Procedures or testing for the inducement of fertility are not a benefit of the Medicaid program. This includes, but is not limited to:

- Artificial insemination
- Consultations
- Counseling
- Office exams
- Tuboplasties
- Vasovasotomies

3.6.2.6 Take Home Drugs

Outpatient take-home drug charges that exceed $4.00 must be billed on the Idaho Medicaid pharmacy claim form. Inpatient take-home drugs dispensed upon discharge must also be submitted on the pharmacy claim form.

3.6.2.7 Examinations

Examinations for the following are not payable.

- Routine examinations, other than those associated with the EPSDT program
- Examinations related to attendance, participation, enrollment, or accomplishment of a program
- Examinations related to employment
- Premarital examination

3.6.3 Exceptions

Some excluded services/procedures that require treatment, services, or supplies not included in the regular scope of Medicaid coverage may be payable when identified as medically necessary during an EPSDT screen. Such excluded services/procedures must be prior authorized by Medicaid.

Some examples of the services for which payment may be made are substance abuse treatment and private duty nursing in the client's home. Any service recognized under the provisions of the Social Security Act can be made available if the above conditions are met.

3.6.4 Mammography Services

Idaho Medicaid will cover screening or diagnostic mammographies performed with mammography equipment and staff that is considered certifiable or certified by the Bureau of Laboratories.

- Screening mammographies will be limited to one (1) per calendar year for women who are forty (40) or more years of age.
- Diagnostic mammographies will be covered when a physician orders the procedure for a patient of any age who is at high risk.

3.6.5 Freestanding Dialysis Units

Outpatient dialysis procedures provided by a freestanding dialysis facility should be billed on a UB92 claim form in the following manner:

- Report with bill-type 721 through 724. Refer to *Section 3.1.4* for more information.
- Medicare crossover claims (Medicare is primary insurance) cannot be sent electronically to Idaho Medicaid from Medicare and therefore, must be submitted to Idaho Medicaid on a paper claim form with the MRN from Medicare attached.
- Dialysis procedures are reported with the following revenue codes:

  821 outpatient dialysis; CPT code 90999 (hemodialysis composite or other rate)

  270 dialysis supplies (medical surgical supplies)

  272 special supplies (sterile supplies)

  634 Epoetin up to 10,000 units (one billing unit = 1000 units) CPT

  635 Epoetin over 10,000 units (one billing unit = 1000 units) CPT

636 dialysis drugs [CPT] (drugs requiring detailed coding); use the appropriate corresponding J-code from the most current HCPCS book and attach the NDC detail attachment with the claim form (see Medicaid Information Release MA03-69)

If billing using a date span, make sure the header date span is reflected in the detail dates. ***Note****: Each date of service must be billed on a separate detail line.*

3.7 Revenue Codes

3.7.1 Overview

All hospital services must be billed using the following unique, three-digit revenue codes. EDS will deny any claim with any other revenue codes entered.

3.7.2 Accommodation Revenue Codes

PO These revenue codes must have a signed physician's order attached to the claim form.

Rev Code	Service	Description	Patient Status
100	All Inclusive Room-Board plus Ancillary and Swing Bed	Not covered.	
101	All Inclusive Room-Board		In
110	Private	Not covered.	
111	Medical/Surgical/GynPO		In
112	ObstetricPO	When using this revenue code for birthing room accommodation make sure the facility has an accommodation rate on file and specify *Birthing Room* in the in the Remarks field (Field 84) of the UB92 claim form	In
113	PediatricPO		In
114	PsychiatricPO		In
115	Hospice	Must be billed using hospice provider number	
116	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. Documentation of the physician's order for the bed must be attached.	In
117	OncologyPO		In
118	RehabilitationPO		In
119	Other	Not covered	
120	Room and Board, Semiprivate		In
121	Medical/Surgical/Gyn		In
122	Obstetric		In
123	Pediatric		In
124	Psychiatric		In
125	Hospice	Not covered.	
126	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. Documentation of the physician's order for the bed must be attached.	In
127	Oncology		In
128	Rehabilitation		In
129	Other	Not covered.	
130	Semiprivate — 3 and 4 Beds		In
131	Medical/Surgical/Gyn		In

Rev Code	Service	Description	Patient Status
132	Obstetric		In
133	Pediatric		In
134	Psychiatric		In
135	Hospice	Not covered.	
136	Detoxification	Medicaid will reimburse for acute level of care medical conditions only. Documentation of the physician's order for the bed must be attached.	In
137	Oncology		In
138	Rehabilitation		In
139	Other	Not covered.	
140	Private (Luxury)PO		In
141	Medical/Surgical/Gyn (Luxury)PO		In
142	Obstetric (Luxury)PO		In
143	Pediatric (Luxury)PO		In
144	Psychiatric (Luxury)PO		In
145	Hospice	Not covered.	
146	Detoxification (Luxury)PO	Medicaid will reimburse for acute level of care medical conditions only. Documentation of the physician's order for the bed must be attached.	In
147	Oncology (Luxury)PO		In
148	Rehabilitation (Luxury)PO		In
149	Other	Not covered.	
150	Room and Board, Ward		In
151	Medical/Surgical/Gyn		In
152	Obstetric		In
153	Pediatric		In
154	Psychiatric		In
155	Hospice	Not covered.	
156	DetoxificationPO	Medicaid will reimburse for acute level of care medical conditions only. Documentation of the physician's order for the bed must be attached.	In
157	Oncology		In
158	Rehabilitation		In
159	Other	Not covered.	
160	Other Room and Board	Not covered.	
164	Room and Board, Sterile EnvironmentPO		In
167	Self Care	Not covered.	
169	Other	Not covered.	
170	Nursery		In
171	Newborn-Level 1		In
172	Premature-Level II		In

Rev Code	Service	Description	Patient Status
173	Newborn-Level III		In
174	Newborn-Level IV-NICU		In
179	Other — Nursery	Not covered.	
180	LOA	Not covered.	
181	Reserved	Not covered.	
182	Client Convenience	Not covered.	
183	Therapeutic Leave	Not covered.	
189	Other Leave of Absence	Not covered.	
200	Intensive Care Unit (ICU)		In
201	Surgical		In
202	Medical		In
203	Pediatrics		In
204	Psychiatric		In
206	Post ICU	Not covered.	
207	Burn Care		In
208	Trauma		In
209	Other Intensive Care	Not covered.	
210	Coronary Care Unit (CCU)		In
211	Myocardial Infarction		In
212	Pulmonary Care		In
213	Heart Transplant		In
214	Post CCU	Not covered.	
219	Other Coronary Care	Not covered.	

3.7.3 Ancillary Revenue Codes

CPT Must indicate a valid CPT procedure code when billing outpatient claims.

HCPCS Must indicate a valid HCPCS procedure code when billing outpatient claims.

Rev Code	Service	Description	Patient Status
220	Special Charges	Not covered.	
221	Admission Charge	Not covered.	
222	Technical Support Charge	Not covered.	
223	UR Service Charge	Not covered.	
224	Late Discharge, Medically Necessary	Not covered.	
229	Other Special Charges	Not covered.	
230	Incremental Nursing Charge		In
231	Nursery		In
232	OB		In
233	ICU		In
234	CCU		In
235	Hospice	Must bill using hospice provider number.	
239	Other	Not covered.	
240	All Inclusive Ancillary	Not covered.	
249	Other Inclusive Ancillary	Not covered.	
250	Pharmacy		In/Out
251	Generic Drugs		In/Out
252	Nongeneric Drugs		In/Out
253	Take Home Drugs	Must be under $4.00. Do not reduce charge to $4.00 and bill as an outpatient service. Bill correct amount on the pharmacy claim form if amount exceeds $4.00.	Out
254	Drugs Incident to other Diagnostic Services	Not covered.	
255	Drugs Incident to Radiology		In/Out
256	Experimental Drugs	Not covered.	
257	Non-prescription		In/Out
258	IV Solutions		In/Out
259	Other Pharmacy	Not covered.	
260	IV Therapy		In/Out
261	Infusion Pump		In/Out
262	IV Therapy Pharmacy Services		In/Out
263	IV Therapy/Drug/ Supply Delivery		In/Out
264	IV Therapy/Supplies		In/Out
269	Other IV Therapy	Not covered.	
270	Medical/Surgical Supplies and Devices	Extraordinary volume on TPN with prior approval only.	In/Out

Rev Code	Service	Description	Patient Status
271	Nonsterile Supply		In/Out
272	Sterile Supply		In/Out
273	Take Home Supplies	Not covered.	
274	Prosthetic/Orthotic Devices	Medicaid pays for permanent or temporary medical prosthetics to reinforce or replace a biological part implanted through surgery. Devices must be prescribed by the physician. Devices without FDA approval are not covered. Document specific device information in the Remarks field (Field 84) of the UB92 claim form. See Section 3.1.4 of the **Ambulatory Surgical Center Guidelines** for more specific information	In/Out
275	Pacemaker		In/Out
276	Intraocular Lens		In/Out
277	Oxygen-Take Home	Not covered.	
278	Other Implant	Indicate in the Remarks field (Field 84) of the UB92 claim form the specific device or implant used. See Section 3.1.4 of the **Ambulatory Surgical Center Guidelines** for more specific information	In/Out
279	Other Devices	Not covered.	
280	Oncology General		In/Out
289	Oncology Other		In/Out
290	DME (other than renal)	Not covered.	
291	Rental	Not covered.	
292	Purchase of New DME	Not covered.	
293	Purchase of Used DME	Not covered.	
294	Supplies/Drugs for DME	Not covered.	
299	Other Equipment	Not covered.	
300	Laboratory CPT		In/Out
301	Chemistry CPT		In/Out
302	Immunology CPT		In/Out
303	Renal Patient (Home) CPT		
304	Non-routine Dialysis CPT		In/Out
305	Hematology CPT		In/Out
306	Bacteriology & Microbiology CPT		In/Out
307	Urology CPT		In/Out
309	Other Laboratory	Not covered.	
310	Laboratory Pathological		In/Out
311	Cytology		In/Out
312	Histology		In/Out
314	Biopsy		In/Out
319	Other	Not covered.	
320	Radiology Diagnostic CPT		In/Out
321	Angiocardiography CPT		In/Out

Rev Code	Service	Description	Patient Status
322	Arthrography CPT		In/Out
323	Arteriography CPT		In/Out
324	Chest X-ray CPT		In/Out
329	Other	Not covered.	
330	Radiology Therapeutic		In/Out
331	Chemotherapy - Injected		In/Out
332	Chemotherapy - Oral		In/Out
333	Radiation Therapy		In/Out
335	Chemotherapy - IV		In/Out
339	Other	Not covered.	
340	Nuclear Medicine CPT		In/Out
341	Diagnostic CPT		In/Out
342	Therapeutic		In/Out
349	Other	Not covered.	
350	CT Scan CPT		In/Out
351	Head Scan CPT		In/Out
352	Body Scan CPT		In/Out
359	Other CT Scans	Not covered.	
360	Operating Room Services CPT		In/Out
361	Minor Surgery CPT		In/Out
362	Organ Transplant — Other than kidney		In/Out
367	Kidney Transplant		In/Out
369	Other OR Services	Not covered.	
370	Anesthesia		In/Out
371	Anesthesia Incident to Radiology		In/Out
372	Anesthesia Incident to Other Diagnostic Services		In/Out
374	Acupuncture	Not covered.	
379	Other Anesthesia	Not covered.	
380	Blood		In/Out
381	Packed Red Cells		In/Out
382	Whole Blood		In/Out
383	Plasma		In/Out
384	Platelets		In/Out
385	Leukocytes		In/Out
386	Other Components		In/Out
387	Other Derivatives (Cryopricipitates)		In/Out
389	Other Blood	Not covered.	
390	Blood Storage and Processing		In/Out
391	Blood Administration	(e.g., transfusions)	In/Out

Rev Code	Service	Description	Patient Status
399	Other Blood Storage/ Processing	Not covered.	
400	Other Imaging Service CPT		In/Out
401	Diagnostic Mammography CPT	Must be physician ordered.	In/Out
402	Ultrasound CPT		In/Out
403	Screening Mammography CPT	Physician's order is not required. Client must be age 40 or older.	In/Out
404	Position Emission Tomography (PET) HCPCS	Must report appropriate HCPCS code. See Information Release 2003-72	In/Out
409	Other Imaging Service	Not covered.	
410	Respiratory Services		In/Out
412	Inhalation Services		In/Out
413	Hyperbaric Oxygen Therapy		In/Out
419	Other Respiratory Service	Not covered.	
420	Physical Therapy	Indicate units by visits not modalities for outpatient services. Only 25 visits per calendar year are allowed regardless of provider. 1 unit = 1 visit.	In/Out
421	Visit Charge	Not covered.	
422	Hourly Charge	Not covered.	
423	Group Rate	Not covered.	
424	Evaluation or Re-evaluation		In/Out
429	Other Physical Therapy	Consultations and conferences are not billable as other therapy. Indicate specific service in the Remarks field (Field 84) of the UB92 claim form, such as whirlpool therapy or hot packs.	In/Out
430	Occupational Therapy		In/Out
431	Visit Charge	Not covered.	
432	Hourly Charge	Not covered.	
433	Group Rate	Not covered.	
434	Evaluation or Re-evaluation Occupational Therapy		In/Out
439	Other Occupational Therapy	Services are not payable if for fitting or related to the training or education of a client with an artificial limb. Consultations and conferences are not billable as other occupational therapy. Indicate specific service in the Remarks field (Field 84) of the UB92 claim form.	In/Out
440	Speech — Language Pathology	Only 250 visits per calendar year are allowed. 1 unit = 1 visit.	In/Out
441	Visit Charge	Not covered.	
442	Hourly Charge	Not covered.	
443	Group Rate	Not covered.	
444	Evaluation or Re-evaluation Speech/Lang.		In/Out
449	Other Speech-Language Pathology	Not covered.	

Rev Code	Service	Description	Patient Status
450	Emergency Room		In/Out
459	Other Emergency Room	Not covered.	
460	Pulmonary Function		In/Out
469	Other Pulmonary Function	Not covered.	
470	Audiology		In/Out
471	Diagnostic		In/Out
472	Treatment		In/Out
479	Other Audiology	Not covered.	
480	Cardiology		In/Out
481	Cardiac Cath Lab		In/Out
482	Stress Test		In/Out
483	Echocardiology		In/Out
489	Other Cardiology		In/Out
490	Ambulatory Surgical Care CPT	Must report appropriate CPT or HCPCS when applicable	Out
499	Other ASC Care	Not covered.	
500	Outpatient Services		Out
509	Other — Outpatient Services	Not covered.	
510	Clinic	Not covered.	
511	Chronic Pain Center	Not covered.	
512	Dental Clinic	Not covered.	
513	Psychiatric Clinic	Not covered.	
514	OB-GYN Clinic	Not covered.	
515	Pediatric Clinic	Not covered.	
519	Other Clinic		Out
520	Free Standing Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form.	
521	Rural Health — Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form.	
522	Rural Health — Home	Service not covered on this claim type. Must bill on a CMS 1500 form.	
523	Family Practice Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form.	
529	Other Free Standing Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form.	
530	Osteopathic Services		In/Out
531	Osteopathic Therapy		In/Out
539	Other Osteopathic Service	Not covered.	
540	Ambulance: Ground Ambulance Non-emergency	Hospital owned and operated ambulance services should be billed using the hospital's Medicaid provider number. Requires Medicaid Ambulance Review authorization.	In/Out
541	Ambulance Supplies		In/Out

Rev Code	Service	Description	Patient Status
542	Medical Transport: Ground Ambulance Emergency	Hospital owned and operated ambulance services should be billed using the hospital's Medicaid provider number. Requires Medicaid Ambulance Review authorization.	In/Out
543	Heart Mobile	Not Covered	
544	Ambulance Oxygen	Includes oxygen-related equipment	In/Out
545	Air Ambulance- All Levels of Life Support		In/Out
546	Neonatal Ambulance Services: Ground or Air Ambulance		In/Out
547	Ambulance Pharmacy		In/Out
548	Ambulance EKG Services	Telephone transmission EKG	Out
549	Other Ambulance	Respond and evaluate	
550	Skilled Nursing (S9123) HCPCS Requires modifier "U5"	HCPCS code must be indicated in Field 44 on the UB92. Restricted to pregnant women only. Not to exceed two visits per pregnancy. Also used to bill home health services. Must bill using home health provider number.	In/Out
551	Skilled Nursing Visit	Must bill using home health provider number.	
552	Hourly Charge	Not covered.	
559	Maternity Nursing Visits (T1001) HCPCS Requires modifier "U5"	HCPCS code must be indicated in Field 44 on the UB92. Restricted to pregnant women only.	Out
560	Medical Social Services		In
561	Individual & Family Social Services (S9127) HCPCS Requires modifier "U5"	HCPCS code must be indicated in Field 44 on the UB92. Restricted to pregnant women only. Not to exceed two visits.	Out
562	Hourly Charge	Not covered.	
569	Risk Reduction Follow-up (G9005) HCPCS	HCPCS code must be indicated in Field 44 on the UB92. Restricted to pregnant women only.	Out
570	Home Health Aide	Not covered	
571	Home Health Visit Charge	Home Health claims are billed on a UB92.	
572	Hourly Charge	Not covered.	
579	Other Home Health Aide	Not covered.	
580	Other Visits — Home Health	Not covered.	
581	Visit Charge	Not covered.	
582	Hourly Charge	Not covered.	
589	Other Home Health Visits	Not covered.	
590	Units of Service — Home Health	Not covered.	
599	Home Health — Other Units	Not covered.	
600	Oxygen — Home Health	Not covered.	
601	Oxygen — Equipment, Supply, Cont.	Not covered.	

Rev Code	Service	Description	Patient Status
602	Oxygen — State, Equipment, Supply, Under 1 LPM	Not covered.	
603	Oxygen — State, Equipment, Over 4 LPM	Not covered.	
604	Oxygen — Portable Add-on	Not covered.	
610	MRT CPT		In/Out
611	MRI — Brain and Brainstem CPT		In/Out
612	MRI — Spine and Spinal Cord CPT		In/Out
614	MRI – Other CPT		In/Out
615	MRA – Head and Neck CPT		In/Out
616	MRA – Lower extremities CPT		In/Out
618	MRA – Other CPT		In/Out
619	Other MRT	Not covered.	
621	Supplies Incident to Radiology		In/Out
622	Supplies Incident to Other Diagnostic Services		In/Out
623	Surgical Dressings		In/Out
630	Drug Home IV Sol.	Not covered.	
631	Single Source	Not covered.	
632	Multiple Source	Not covered.	
633	Restrictive Prescription	Not covered.	
634	EPO < 10000 Units CPT	Less than 10,000 units	Out
635	EPO > 10000 Units CPT	10,000 or more units	Out
636	Drugs Requiring Detailed Coding CPT		Out
640	IV Therapy Services	Not covered.	
641	Non-routine Nursing, Central Line	Not covered.	
642	IV Site Care, Central Line.	Not covered.	
643	IV Start/Change, Peripheral Line	Not covered.	
644	Non-routine Nursing, Peripheral Line	Not covered.	
645	Training Client/Caregiver, Central Line	Not covered.	
646	Training Disabled Client, Central Line	Not covered.	
647	Training Client Caregiver, Peripheral Line	Not covered.	
648	Training Disabled Client, Peripheral Line	Not covered.	
649	Other IV Therapy Services	Not covered.	
650	Hospice Services	Must bill using hospice provider number.	
651	Routine Home Care	Must bill using hospice provider number.	
652	Continuous Home Care	Must bill using hospice provider number.	

Rev Code	Service	Description	Patient Status
655	Inpatient Respite Care	Must bill using hospice provider number.	
656	General Inpatient Care	Must bill using hospice provider number.	
657	Physician Services CPT	Must bill using hospice provider number.	
659	Other Hospice	Must bill using hospice provider number.	
660	Respite Care/HHA	Not covered.	
661	Hourly Charge/Skilled Nursing	Not covered.	
662	Hourly Charge/Home Health	Not covered.	
671	Outpatient Special Residence Charges – Hospital Based – Administratively Necessary Day	Effective October 20, 2003, use revenue code 671 in place of revenue code 074	Out
700	Cast Room		In/Out
709	Other Cast Room	Not covered.	
710	Recovery Room		In/Out
719	Other Recovery Room	Not covered.	
720	Labor Room/Delivery		In/Out
721	Labor		In/Out
722	Delivery		In/Out
723	Circumcision		In/Out
724	Birthing Center	Charge must reflect a service area not an accommodation (inpatient bed, etc.)	In/Out
729	Other Labor/Delivery	Not covered.	
730	EKG/ECG		In/Out
731	Holter Monitor		In/Out
732	Telemetry (Including Fetal Monitor)		In/Out
739	Other EKG/ECG	Not covered.	
740	EEG		In/Out
749	Other EEG	Not covered.	
750	Gastro-Intestinal Services		In/Out
759	Other Gastro-Intestinal	Not covered.	
760	Treatment/ Observation Room	Effective October 20, 2003 use revenue code 760 or 762 instead of revenue code 073	In/Out
761	Treatment Room		In/Out
762	Observation Room	Effective October 20, 2003 use revenue code 760 or 762 instead of revenue code 073	In/Out
769	Other Treatment Room	Not covered.	
771	Vaccine Administration CPT		Out
790	Lithotripsy		In/Out
799	Other Lithotripsy	Not covered.	
800	Inpatient Renal Dialysis		In
801	Inpatient Hemodialysis		In
802	Inpatient Peritoneal (Non-CAPD)		In

Rev Code	Service	Description	Patient Status
803	Inpatient CAPD		In
804	Inpatient CCPD		In
809	Other Inpatient Dialysis	Not covered.	
810	Organ Acquisition		In/Out
811	Living Donor		In/Out
812	Cadaver Donor		In/Out
813	Unknown Donor		In/Out
814	Unsuccessful Organ Search – Donor Bank Charges	Used only when costs incurred for an organ search do not result in an eventual organ acquisition and transplantation	In/Out
815	Cadaver Donor		In/Out
816	Other Heart Acquisition		In/Out
817	Donor-Liver		In/Out
819	Other Organ Acquisition		In/Out
820	Hemodialysis Outpatient or Home		Out
821	Hemodialysis/Composite or Other Rate CPT		Out
822	Home Supplies	Not covered.	
823	Home Equipment	Not covered.	
824	Maintenance 100%	Not covered.	
825	Support Services	Not covered.	
829	Other Outpatient Hemodialysis	Not covered.	
830	Peritoneal Dialysis – Outpatient or Home		Out
831	Peritoneal/Composite CPT or Other Rate		Out
832	Home Supplies	Not covered.	
833	Home Equipment	Not covered.	
834	Maintenance 100%	Not covered.	
835	Support Services	Not covered.	
839	Other Outpatient Peritoneal	Not covered.	
840	CAPD Outpatient or Home		Out
841	CAPD Composite or Other Rate CPT		Out
842	Home Supplies	Not covered.	
843	Home Equipment	Not covered.	
844	Maintenance 100%	Not covered.	
845	Support Services	Not covered.	
849	Other Outpatient CAPD	Not covered.	
850	CCPD Outpatient or Home		Out
851	CCPD/Composite or Other Rate CPT		Out
852	Home Supplies	Not covered.	
853	Home Equipment	Not covered.	

Rev Code	Service	Description	Patient Status
854	Maintenance 100%	Not covered.	
855	Support Services	Not covered.	
859	Other Outpatient CCPD	Not covered.	
880	Miscellaneous Dialysis		In/Out
881	Ultrafiltration		In/Out
882	Home Dialysis Aid Visit	Not covered.	
889	Other Miscellaneous Dialysis		In/Out
890	Other Donor Bank		In/Out
891	Bone		In/Out
892	Organ Other than Kidney, Liver and Heart		In/Out
893	Skin	Not payable if for cosmetic surgery.	In/Out
899	Other Donor Bank	Not covered.	
900	Psychiatric/Psychological Treatments	Not covered.	
901	Electroshock Treatment		In/Out
902	Milieu Therapy	Not covered.	
903	Play Therapy	Not covered.	
904	Activity Therapy	Not covered.	
909	Other	Not covered.	
910	Psychiatric Services	Not acceptable.	
911	Rehabilitation	Not acceptable.	
912	Partial Hospitalization – Less Intensive	Not covered.	
913	Partial Hospitalization - Intensive	Not covered.	
914	Individual Psychiatric Therapy		In/Out
915	Group Psychiatric Therapy		In/Out
916	Family Psychiatric Therapy		In/Out
917	Bio Feedback	Not covered.	
918	Testing Psychiatric Services		In/Out
919	Other	Not covered.	
920	Other Diagnostic Services	Document specific diagnostic services rendered.	In/Out
921	Peripheral Vascular Lab		In/Out
922	EMG		In/Out
923	Pap Smear		In/Out
924	Allergy Test CPT/HCPCS		In/Out
925	Pregnancy Test		In/Out
929	Other Diagnostic Services	Not covered.	
940	Other Therapeutic Services	Document specific therapeutic services rendered.	In/Out
941	Recreational Therapy		In

Rev Code	Service	Description	Patient Status
942	Education/Training HCPCS	For Diabetes Education and Training, use HCPCS G0108 for Individual Counseling and G0109 for Group Counseling. For PWC or EPSDT nutritional services use S9470. See **Section 3.11, Diabetes Education and Training** or **Section 3.12 Dietician Policy** for more information.	Out
943	Cardiac Rehabilitation	Only payable within six weeks of heart surgery. Indicate the date of surgery and document specific cardiac rehabilitation services rendered.	In/Out
944	Drug Rehabilitation		In/Out
945	Alcohol Rehabilitation		In/Out
946	Complex Medical Equipment – Routine	e.g., Air Fluidized Support Bed	In/Out
947	Complex Medical Equipment – Ancillary		In/Out
949	Other Therapeutic Service	Not covered.	
960	Professional Fees	Service not covered on this claim type. Must bill on a CMS 1500 form.	
961	Psychiatric	Service not covered on this claim type. Must bill on a CMS 1500 form.	
962	Ophthalmology	Service not covered on this claim type. Must bill on a CMS 1500 form	
963	Anesthesiologist (MD)	Service not covered on this claim type. Must bill on a CMS 1500 form.	
964	Anesthetist (CRNA)	Must bill on a CMS 1500 using the CRNA's provider number, unless there is a Medicare exception to bill using the UB92	In/Out
969	Other Professional Fees	Service not covered on this claim type. Must bill on a CMS 1500 form.	
971	Laboratory	Service not covered on this claim type. Must bill on a CMS 1500 form.	
972	Radiology Diagnostic	Service not covered on this claim type. Must bill on a CMS 1500 form.	
973	Radiology — Therapeutic	Service not covered on this claim type. Must bill on a CMS 1500 form.	
974	Radiology — Nuclear Medicine	Service not covered on this claim type. Must bill on a CMS 1500 form.	
975	Operating Room	Service not covered on this claim type. Must bill on a CMS 1500 form.	
976	Respiratory Therapy	Service not covered on this claim type. Must bill on a CMS 1500 form.	
977	Physical Therapy	Service not covered on this claim type. Must bill on a CMS 1500 form.	
978	Occupational Therapy	Service not covered on this claim type. Must bill on a CMS 1500 form.	
979	Speech Pathology	Service not covered on this claim type. Must bill on a CMS 1500 form.	
981	Emergency Department	Service not covered on this claim type. Must bill on a CMS 1500 form.	

Rev Code	Service	Description	Patient Status
982	Outpatient Services	Service not covered on this claim type. Must bill on a CMS 1500 form.	
983	Clinic	Service not covered on this claim type. Must bill on a CMS 1500 form.	
984	Medical Social Services	Service not covered on this claim type. Must bill on a CMS 1500 form.	
985	EKG	Service not covered on this claim type. Must bill on a CMS 1500 form.	
986	EEG	Service not covered on this claim type. Must bill on a CMS 1500 form.	
987	Hospital Visit	Service not covered on this claim type. Must bill on a CMS 1500 form.	
988	Consultation	Service not covered on this claim type. Must bill on a CMS 1500 form.	
989	Private Duty Nurse	Not covered.	
990	Patient Convenience Items	Not covered.	
991	Cafeteria/Guest Tray	Not covered.	
992	Private Linen Service	Not covered.	
993	Telephone/Telegraph	Not covered.	
994	TV/Radio	Not covered.	
995	Nonpatient Room Rentals	Not covered.	
996	Late Discharge Rate	Not covered.	
997	Admission Kit		In
998	Beauty/Barber Shop	Not covered.	
999	Other Client Convenience	Not covered.	

3.8 Ambulatory Surgical Procedures/CPT Codes

3.8.1 Ambulatory Surgical Care

Medicaid allows interim payments for specific outpatient surgical procedures using the Medicaid fee schedule for ambulatory surgical centers (ASC). This section will be updated periodically with revisions appearing in the newsletters from EDS. The CPT codes listed for the ASC procedures must match the CPT codes used by the primary physician's billing.

See **Section 3.9, Ambulatory Surgical CPT Codes**, for a list of ASC codes and assigned levels. Procedures are subject to the Medicaid fee schedule

ASC procedures should be submitted with type of bill **831** using revenue code **490** with the appropriate five-digit CPT code in the corresponding procedure code field. Revenue code **490**, ambulatory surgical care, is used to represent operating room charges. Each claim must identify the charges for each ancillary service by the revenue code that describes the service. For example, charges for the operating room (**490**), recovery room (**71X**), medical supplies (**27X**), anesthesia (**37X**), or drugs (**25X**) would be listed in the charge column.

3.8.2 Multiple Procedures

Multiple ASC procedures must be listed separately with a CPT code for each procedure. It is not necessary to break out the operating room charges for each line that a procedure is billed under revenue code **490**. The hospital may list all ASC procedures with only one total charge per revenue code. Any ASC procedure code billed with revenue code **490** may display the total operating room charges. Each of the other lines billing operating room revenue code (**490**) with an ASC procedure code may have a total charge of zero entered. Other ancillary services "Included In" the procedure(s) must be billed with the related total customary charges on each line. Ancillary charges must not be bundled into revenue code **490**.

Payment for multiple ASC procedures will be made at 100 percent of the price on file for the highest fee according to Medicaid's fee for service schedule. Subsequent procedures will be paid at 50 percent of the fee schedule.

3.8.2.1 Non-ASC Procedures

Procedures not included in the Medicaid's list of ASC procedures should be billed with type of bill **131** and revenue code **360** or **361**.

Claims with multiple procedures that have at least one procedure not on the ASC list become outpatient claims payable at the outpatient reimbursement rate on file for that particular hospital. This does not include office procedures.

If an ASC procedure and a non-ASC procedure are performed at the same time, report all procedures, including the ASC procedure, on bill type 131 with revenue code 360 or 361.

3.8.3 Included In

Certain revenue codes are considered to be included in the global fee for the procedure when billed with type of bill 831 and will not be paid separately. The following revenue codes will be denied as "Included In" the global fee.

230	260	370	386	552	760
239	261	371	287	622	761
250	262	372	390	700	762
251	263	380	391	710	920
252	264	381	450	720	
253	270	382	500	721	
255	271	383	510	722	
257	272	384	519	723	
258	276	385	550	750	

Charges for revenue codes that are not considered part of the global fee should be billed on a separate claim with type of bill 131. Include justification on the claim or in the narrative field on NECS claims. Laboratory and radiology fees are paid at Medicaid's fee schedule. Revenue codes that are not on the "Included In" list are paid at the outpatient reimbursement rate on file.

3.8.4 Bundling

Charges for ASC claims should not be bundled under revenue code **490**. All charges should be listed under the appropriate revenue codes as on outpatient claims. Charges denied as "Included In" are calculated as part of the tally in determining payment at the time cost settlement occurs.

3.8.5 Dental Procedures

Healthy Connections clients require a referral from their primary care provider for any dental services provided in a hospital or ASC.

Medicaid reimburses for all of these services with a single fee under the surgical procedure code 41899. Use the procedure code 41899 when billing for prior authorized dental procedures.

When billing for dental services performed in the outpatient setting, use bill type **831**, revenue code **490,** and procedure code **41899**.

3.9 Ambulatory Surgical CPT Codes

3.9.1 Overview

Consult your CPT manual for descriptions of these codes. The column “ASC Level” in the table for all CPT codes below, excluding dental, is the level of payment to the provider for the listed procedure code.

3.9.2 Integumentary System

CPT Code	ASC Level
10121	02
10180	02
11010	02
11011	02
11012	02
11042	02
11043	02
11044	02
11404	01
11406	02
11420	01
11424	02
11426	02
11444	01
11446	02
11450	02
11451	02
11462	02
11463	02
11470	02
11471	02
11604	02
11606	02
11624	02
11626	02
11644	02
11646	02
11770	03
11771	03
11772	03
11960	02
11970	03
11971	01
12005	02
12006	02
12007	02
12016	02
12017	02
12018	02
12020	01
12021	01
12034	02
12035	02
12036	02

CPT Code	ASC Level
12037	02
12044	02
12045	02
12046	02
12047	02
12054	02
12055	02
12056	02
12057	02
13100	02
13101	03
13102	02
13120	02
13121	03
13122	02
13131	02
13132	03
13133	02
13150	03
13151	03
13152	03
13153	03
13160	02
14000	02
14001	03
14020	03
14021	03
14040	02
14041	03
14060	03
14061	03
14300	04
14350	03
15000	02
15001	02
15050	02
15100	02
15101	03
15120	02
15121	03
15200	03
15201	02
15220	02
15221	02

CPT Code	ASC Level
15240	03
15241	03
15260	02
15261	02
15350	02
15351	02
15400	02
15401	02
15570	03
15572	03
15574	03
15576	03
15600	03
15610	03
15620	04
15630	03
15650	05
15732	03
15734	03
15736	03
15738	03
15740	02
15750	02
15760	02
15770	03
15775	03
15776	03
15820	03
15821	03
15822	03
15823	05
15824	03
15825	03
15826	03
15828	03
15829	05
15831	03
15832	03
15833	03
15834	03
15835	03
15840	04
15841	04
15845	04

CPT Code	ASC Level
15876	03
15877	03
15878	03
15879	03
15920	03
15922	04
15931	03
15933	03
15934	03
15935	04
15936	04
15937	04
15940	03
15941	03
15944	03
15945	04
15946	04
15950	03
15951	04
15952	03
15953	04
15956	03
15958	04
16015	02
19020	02
19100	01
19101	02
19102	02
19103	02
19110	02
19112	03
19120	03
19125	03
19126	03
19140	04
19160	03
19162	07
19180	04
19182	04
19290	01
19291	01
19295	01
19316	04
19318	04

CPT Code	ASC Level
19324	04
19325	09
19328	01
19330	01

CPT Code	ASC Level
19340	02
19342	03
19350	04
19355	04

CPT Code	ASC Level
19357	05
19366	05
19370	04
19371	04
19380	05

3.9.3 Musculoskeletal System

CPT Code	ASC Level
20005	02
20200	02
20205	03
20206	01
20220	01
20225	02
20240	02
20245	03
20250	03
20251	03
20520	01
20525	03
20612	01
20650	03
20670	01
20680	03
20690	02
20692	03
20693	03
20694	01
20900	03
20902	04
20910	03
20912	03
20920	04
20922	03
20924	04
20926	04
20975	02
21010	02
21015	03
21025	02
21026	02
21029	02
21030	01
21034	03
21040	02
21044	02
21046	02
21047	02
21048	08
21049	08
21050	03
21060	02
21070	03

CPT Code	ASC Level
21100	02
21121	07
21122	07
21123	07
21127	09
21181	07
21206	05
21208	07
21209	05
21210	07
21215	07
21230	07
21235	07
21240	04
21242	05
21243	05
21244	07
21245	07
21246	07
21248	07
21249	07
21267	07
21270	05
21275	07
21280	05
21282	05
21295	01
21296	01
21300	02
21310	02
21315	02
21320	02
21325	04
21330	05
21335	07
21336	04
21337	02
21338	04
21339	05
21340	04
21345	07
21355	03
21400	02
21401	03
21421	04

CPT Code	ASC Level
21440	03
21445	04
21450	03
21451	04
21452	02
21453	03
21454	05
21461	04
21462	05
21465	04
21480	01
21485	02
21490	03
21493	03
21494	04
21497	02
21501	02
21502	02
21555	02
21556	02
21600	02
21610	02
21700	02
21720	03
21725	03
21742	01
21743	01
21800	01
21805	02
21820	01
21925	02
21930	02
21935	03
22305	01
22310	01
22315	02
22505	02
22900	04
23000	02
23020	02
23030	01
23031	03
23035	03
23040	03
23044	04

CPT Code	ASC Level
23066	02
23075	02
23076	02
23077	03
23100	02
23101	07
23105	04
23106	04
23107	04
23120	05
23125	05
23130	05
23140	04
23145	05
23146	05
23150	04
23155	05
23156	05
23170	02
23172	02
23174	02
23180	04
23182	04
23184	04
23190	04
23195	05
23330	01
23331	01
23395	05
23397	07
23400	07
23405	02
23406	02
23410	05
23412	07
23415	05
23420	07
23430	04
23440	04
23450	05
23455	07
23460	05
23462	07
23465	05
23466	07

CPT Code	ASC Level
23480	04
23485	07
23490	03
23491	03
23500	01
23505	01
23515	03
23520	01
23525	01
23530	03
23532	04
23540	01
23545	01
23550	03
23552	04
23570	01
23575	01
23585	03
23600	01
23605	02
23615	04
23616	04
23620	01
23625	02
23630	05
23650	01
23655	01
23660	03
23665	02
23670	03
23675	02
23680	03
23700	01
23800	04
23802	07
23921	03
23930	01
23931	02
23935	02
24000	04
24006	04
24066	02
24075	02
24076	02
24077	03
24100	01
24101	04
24102	04
24105	03
24110	02
24115	03
24116	03
24120	03

CPT Code	ASC Level
24125	03
24126	03
24130	03
24134	02
24136	02
24138	02
24140	03
24145	03
24147	02
24155	03
24160	02
24164	03
24201	02
24301	04
24305	04
24310	03
24320	03
24330	03
24331	03
24340	03
24341	03
24342	03
24345	02
24350	03
24351	03
24352	03
24354	03
24356	03
24360	05
24361	05
24362	05
24363	07
24365	05
24366	05
24400	04
24410	04
24420	03
24430	03
24435	04
24470	03
24495	02
24498	03
24500	01
24505	01
24515	04
24516	04
24530	01
24535	01
24538	02
24545	04
24546	05
24560	01
24565	02

CPT Code	ASC Level
24566	02
24575	03
24576	01
24577	01
24579	03
24582	02
24586	04
24587	05
24600	01
24605	02
24615	03
24620	02
24635	03
24655	01
24665	04
24666	04
24670	01
24675	01
24685	03
24800	04
24802	05
24925	03
25000	03
25020	03
25023	03
25024	03
25025	03
25028	01
25031	02
25035	02
25040	05
25066	02
25075	02
25076	03
25077	03
25085	03
25100	02
25101	03
25105	04
25107	03
25110	03
25111	03
25112	04
25115	04
25116	04
25118	02
25119	03
25120	03
25125	03
25126	03
25130	03
25135	03
25136	03

CPT Code	ASC Level
25145	02
25150	02
25151	02
25210	03
25215	04
25230	04
25240	04
25248	02
25250	01
25251	01
25260	04
25263	02
25265	03
25270	04
25272	03
25274	04
25275	04
25280	04
25290	03
25295	03
25300	03
25301	03
25310	03
25312	04
25315	03
25316	03
25320	03
25332	05
25335	03
25337	05
25350	03
25355	03
25360	03
25365	03
25370	03
25375	04
25390	03
25391	04
25392	03
25393	04
25400	03
25405	04
25415	03
25420	04
25425	03
25426	04
25440	04
25441	05
25442	05
25443	05
25444	05
25445	05
25446	07

CPT Code	ASC Level
25447	05
25449	05
25450	03
25455	03
25490	03
25491	03
25492	03
25505	01
25515	03
25520	01
25525	04
25526	05
25535	01
25545	03
25565	02
25574	03
25575	03
25605	03
25611	03
25620	05
25624	02
25628	03
25635	01
25645	03
25660	01
25670	03
25671	01
25675	01
25676	02
25680	02
25685	03
25690	01
25695	02
25800	04
25805	05
25810	05
25820	04
25825	05
25830	05
25907	03
25922	03
25929	03
26011	01
26020	02
26025	01
26030	02
26034	02
26040	04
26045	03
26055	02
26060	02
26070	02
26075	04

CPT Code	ASC Level
26080	04
26100	02
26105	01
26110	01
26115	02
26116	02
26117	03
26121	04
26123	04
26125	04
26130	03
26135	04
26140	02
26145	03
26160	03
26170	03
26180	03
26185	04
26200	02
26205	03
26210	02
26215	03
26230	07
26235	03
26236	03
26250	03
26255	03
26260	03
26261	03
26262	02
26320	02
26350	01
26352	04
26356	04
26357	04
26358	04
26370	04
26372	04
26373	03
26390	04
26392	03
26410	03
26412	03
26415	04
26416	03
26418	04
26420	04
26426	03
26428	03
26432	03
26433	03
26434	03
26437	03

CPT Code	ASC Level
26440	03
26442	03
26445	03
26449	03
26450	03
26455	03
26460	03
26471	02
26474	02
26476	01
26477	01
26478	01
26479	01
26480	03
26483	03
26485	02
26489	03
26490	03
26492	03
26494	03
26496	03
26497	03
26498	04
26499	03
26500	04
26502	04
26504	04
26508	03
26510	03
26516	01
26517	03
26518	03
26520	03
26525	03
26530	03
26531	07
26535	05
26536	05
26540	04
26541	07
26542	04
26545	04
26546	04
26548	04
26550	02
26555	03
26560	02
26561	03
26562	04
26565	05
26567	05
26568	03
26580	05

CPT Code	ASC Level
26587	05
26590	05
26591	03
26593	03
26596	02
26605	02
26607	02
26608	04
26615	04
26645	01
26650	02
26665	04
26675	02
26676	02
26685	03
26686	03
26705	02
26706	02
26715	04
26727	07
26735	04
26742	02
26746	05
26756	02
26765	04
26776	02
26785	02
26820	05
26841	04
26842	04
26843	03
26844	03
26850	04
26852	04
26860	03
26861	02
26862	04
26863	03
26910	03
26951	02
26952	04
26990	01
26991	01
27000	02
27001	03
27003	03
27033	03
27035	04
27040	01
27041	02
27047	02
27048	03
27049	03

CPT Code	ASC Level
27050	03
27052	03
27060	05
27062	05
27065	05
27066	05
27067	05
27080	02
27086	01
27087	03
27095	02
27097	03
27098	03
27100	04
27105	04
27110	04
27111	04
27193	01
27194	02
27202	02
27230	01
27238	01
27246	01
27250	01
27252	02
27257	03
27265	01
27266	02
27275	02
27301	03
27305	02
27306	03
27307	03
27310	04
27315	02
27320	02
27323	01
27324	01
27327	02
27328	03
27329	04
27330	04
27331	04
27332	04
27333	04
27334	04
27335	04
27340	03
27345	04
27347	04
27350	04
27355	03
27356	04

CPT Code	ASC Level
27357	05
27358	05
27360	05
27372	07
27380	01
27381	03
27385	03
27386	03
27390	01
27391	02
27392	03
27393	02
27394	03
27395	03
27396	03
27397	03
27400	03
27403	04
27405	04
27407	04
27409	04
27418	03
27420	03
27422	07
27424	03
27425	07
27427	03
27428	04
27429	04
27430	04
27435	04
27437	04
27438	05
27441	05
27442	05
27443	05
27496	05
27497	03
27498	03
27499	03
27500	01
27501	02
27502	02
27503	03
27508	01
27509	03
27510	01
27516	01
27517	01
27520	01
27530	01
27532	01
27538	01

CPT Code	ASC Level
27550	01
27552	01
27560	01
27562	01
27566	02
27570	01
27594	03
27600	03
27601	03
27602	03
27603	02
27604	02
27605	01
27606	01
27607	02
27610	02
27612	03
27614	02
27615	03
27618	02
27619	03
27620	04
27625	04
27626	04
27630	03
27635	03
27637	03
27638	03
27640	02
27641	02
27647	03
27650	03
27652	03
27654	03
27656	02
27658	01
27659	02
27664	02
27665	02
27675	02
27676	03
27680	03
27681	02
27685	03
27686	03
27687	03
27690	04
27691	04
27692	03
27695	02
27696	02
27698	02
27700	05

CPT Code	ASC Level
27704	02
27705	02
27707	02
27709	02
27730	02
27732	02
27734	02
27740	02
27742	02
27745	03
27750	01
27752	01
27756	03
27758	04
27759	04
27760	01
27762	01
27766	03
27780	01
27781	01
27784	03
27788	01
27792	03
27808	01
27810	01
27814	03
27816	01
27818	01
27822	03
27823	03
27824	01
27825	02
27826	03
27827	03
27828	04
27829	02
27830	01
27831	01
27832	02
27840	01
27842	01
27846	03
27848	03
27860	01
27870	04
27871	04
27884	03
27886	03
27889	03
27892	03
27893	03
27894	03
28002	03

CPT Code	ASC Level
28003	03
28005	03
28008	03
28011	03
28020	02
28022	02
28024	02
28030	04
28035	04
28043	02
28045	03
28046	03
28050	02
28052	02
28054	02
28060	02
28062	03
28070	03
28072	03
28080	03
28086	02
28088	02
28090	03
28092	03
28100	02
28102	03
28103	03
28104	02
28106	03
28107	03
28110	03
28111	03
28112	03
28113	03
28114	03
28116	03
28118	04
28119	04
28120	07
28122	03
28124	01
28126	03
28130	03
28140	03
28150	03
28153	03
28160	03
28171	03
28173	03
28175	03
28192	02
28193	04
28200	03
28202	03
28208	03
28210	03
28222	01
28225	01
28226	01
28234	02
28238	03
28240	02
28250	03
28260	03
28261	03
28262	04
28264	01
28270	03
28272	01
28280	02
28285	03
28286	04
28288	03
28289	03
28290	02
28292	02
28293	03
28294	03
28296	03
28297	03
28298	03
28299	05
28300	02
28302	02
28304	02
28305	03
28306	04
28307	04
28308	02
28309	04
28310	03
28312	03
28313	02
28315	04
28320	04
28322	04
28340	03
28341	04
28344	04
28345	04
28400	01
28405	02
28406	02
28415	03
28420	04
28435	02
28436	02
28445	03
28456	02
28465	03
28476	02
28485	04
28496	02
28505	03
28525	03
28531	03
28545	01
28546	02
28555	02
28575	01
28576	03
28585	03
28605	01
28606	02
28615	03
28635	01
28636	03
28645	03
28665	01
28666	03
28675	03
28705	04
28715	04
28725	04
28730	04
28735	04
28737	05
28740	04
28750	04
28755	04
28760	04
28810	02
28820	02
28825	02
29710	01
29800	03
29804	03
29805	03
29819	03
29820	03
29821	03
29822	03
29823	03
29824	05
29825	03
29826	03
29827	05
29830	03
29834	03
29835	03
29836	03
29837	03
29838	03
29840	03
29843	03
29844	03
29845	03
29846	03
29847	03
29848	09
29850	04
29851	04
29855	04
29856	04
29860	04
29861	04
29862	09
29863	04
29870	03
29871	03
29873	08
29874	03
29875	04
29876	04
29877	04
29879	03
29880	04
29881	04
29882	03
29883	03
29884	03
29885	03
29886	03
29887	03
29888	03
29889	03
29891	03
29892	03
29893	09
29894	03
29895	03
29897	03
29898	03
29899	03
29900	03
29901	03
29902	03

3.9.4 Respiratory System

CPT Code	ASC Level
30115	02
30117	03
30118	03
30120	01
30125	02
30130	03
30140	02
30150	03
30160	04
30310	01
30320	02
30400	04
30410	05
30420	05
30430	03
30435	05
30450	07
30460	07
30462	09
30465	09
30520	04
30540	05
30545	05
30560	02
30580	04
30600	04
30620	07
30630	07
30801	01
30802	01
30903	01
30905	01
30906	01
30915	02

CPT Code	ASC Level
30920	03
30930	04
31020	02
31030	03
31032	04
31050	02
31051	04
31070	02
31075	04
31080	04
31081	04
31084	04
31085	04
31086	04
31087	04
31090	05
31200	02
31201	05
31205	03
31233	02
31235	01
31237	02
31238	01
31239	04
31240	02
31254	03
31255	05
31256	03
31267	03
31276	03
31287	03
31288	03
31300	05
31320	02

CPT Code	ASC Level
31400	02
31420	02
31510	02
31511	02
31512	02
31513	02
31515	01
31520	01
31525	01
31526	02
31527	01
31528	02
31529	02
31530	02
31531	03
31535	02
31536	03
31540	03
31541	04
31560	05
31561	05
31570	02
31571	02
31576	02
31577	02
31578	02
31580	05
31582	05
31585	01
31586	02
31588	05
31590	05
31595	02
31611	03

CPT Code	ASC Level
31612	01
31613	02
31614	02
31615	01
31622	01
31623	01
31623	02
31624	02
31625	02
31628	02
31629	02
31630	02
31631	02
31635	02
31640	02
31641	02
31643	02
31645	01
31646	01
31656	01
31700	01
31717	01
31720	01
31730	01
31750	05
31755	02
31820	01
31825	02
31830	02
32000	01
32400	01
32405	01
32420	01

3.9.5 Cardiovascular System

CPT Code	ASC Level
33010	02
33011	02
33215	06
33222	02
33223	02
33224	08
33225	08
33226	06
33508	06
35188	04
35207	04
35860	01
35875	09
35876	09
36260	03
36261	02
36262	01
36536	01
36537	01
36555	01
36556	01

CPT Code	ASC Level
36557	02
36558	02
36560	03
36561	03
36563	03
36565	03
36566	03
36568	01
36569	01
36570	03
36571	03
36575	02
36576	02
36578	02
36580	01
36581	02
36582	03
36583	03
36584	01
36585	03
36589	01

CPT Code	ASC Level
36590	01
36640	01
36800	03
36810	03
36815	03
36819	03
36820	03
36821	03
36825	04
36830	04
36831	09
36832	04
36833	04
36835	04
36860	02
36861	03
36870	09
37203	02
37500	08
37607	03
37609	02

CPT Code	ASC Level
37650	02
37700	02
37720	03
37730	03
37735	03
37760	03
37780	03
37785	03
37790	03

3.9.6 Hemic and Lymphatic Systems

CPT Code	ASC Level
38205	05
38206	05
38300	01
38305	02
38308	02
38500	02

CPT Code	ASC Level
38505	01
38510	02
38520	02
38525	02
38530	02
38542	02

CPT Code	ASC Level
38550	03
38555	04
38570	09
38571	09
38572	09
38740	02

CPT Code	ASC Level
38745	04
38760	02

3.9.7 Digestive System

CPT Code	ASC Level
40500	02
40510	02
40520	02
40525	02
40527	02
40530	02
40650	03
40652	03
40654	03
40700	07
40701	07
40720	07
40761	03

CPT Code	ASC Level
40801	02
40814	02
40816	02
40818	01
40819	01
40831	01
40840	02
40842	03
40843	03
40844	05
40845	05
41005	01
41006	01

CPT Code	ASC Level
41007	01
41008	01
41009	01
41010	01
41015	01
41016	01
41017	01
41018	01
41112	02
41113	02
41114	02
41116	01
41120	05

CPT Code	ASC Level
41250	02
41251	02
41252	02
41500	01
41510	01
41520	02
41800	01
41827	02
42000	02
42107	02
42120	04
42140	02
42145	05

CPT Code	ASC Level
42180	01
42182	02
42200	05
42205	05
42210	05
42215	07
42220	05
42226	05
42235	05
42260	04
42280	01
42300	01
42305	02
42310	01
42320	01
42325	02
42340	02
42405	02
42408	03
42409	03
42410	03
42415	03
42420	07
42425	07
42440	03
42450	02
42500	03
42505	04
42507	03
42508	04
42509	04
42510	04
42600	01
42700	01
42720	01
42725	02
42802	01
42804	01
42806	02
42808	02
42810	03
42815	05
42820	03
42821	05
42825	04
42826	04
42830	04
42831	04
42835	04
42836	04
42860	03
42870	03
42890	07

CPT Code	ASC Level
42892	07
42900	01
42950	02
42955	02
42960	01
42962	02
42972	03
43200	01
43201	01
43202	01
43204	01
43205	01
43215	01
43216	01
43217	01
43219	01
43220	01
43226	01
43227	02
43228	02
43231	02
43232	02
43234	01
43235	01
43236	02
43239	02
43240	02
43241	02
43242	02
43243	02
43244	02
43245	02
43246	02
43247	02
43248	02
43249	02
43250	02
43251	02
43255	02
43256	03
43258	03
43259	03
43260	02
43261	02
43262	02
43263	02
43264	02
43265	02
43267	02
43268	02
43269	02
43271	02
43272	02

CPT Code	ASC Level
43450	01
43453	01
43456	02
43458	02
43600	01
43653	09
43750	02
43760	01
43870	01
44100	01
44206	09
44207	09
44208	09
44312	01
44340	03
44360	02
44361	02
44363	02
44364	02
44365	02
44366	02
44369	02
44370	09
44372	02
44373	02
44376	02
44377	02
44378	02
44379	09
44380	01
44382	01
44383	09
44385	01
44386	01
44388	01
44389	01
44390	01
44391	01
44392	01
44393	01
44394	01
44397	01
45000	01
45005	02
45020	02
45100	01
45108	02
45150	02
45160	02
45170	02
45190	09
45305	01
45307	01

CPT Code	ASC Level
45308	01
45309	01
45315	01
45317	01
45320	01
45321	01
45327	01
45331	01
45332	01
45333	01
45334	01
45335	01
45337	01
45338	01
45339	01
45340	01
45341	01
45342	01
45345	01
45355	01
45378	02
45379	02
45380	02
45381	02
45382	02
45383	02
45384	02
45385	02
45386	02
45387	02
45500	02
45505	02
45560	02
45900	01
45905	01
45910	01
45915	01
46020	03
46030	01
46040	03
46045	02
46050	01
46060	02
46080	03
46200	02
46210	02
46211	02
46220	01
46250	03
46255	03
46257	03
46258	03
46260	03

CPT Code	ASC Level
46261	04
46262	04
46270	03
46275	03
46280	04
46285	01
46288	04
46608	01
46610	01
46611	01
46612	01
46615	02
46700	03
46706	01
46750	03
46753	03
46754	02
46760	02
46761	03
46762	07
46917	01

CPT Code	ASC Level
46922	01
46924	01
46937	02
46938	02
46945	01
47000	01
47510	02
47511	09
47525	01
47530	01
47552	02
47553	03
47554	03
47555	03
47556	09
47560	03
47561	03
47630	03
48102	01
49080	02
49081	02

CPT Code	ASC Level
49085	02
49180	01
49250	04
49320	03
49321	04
49322	04
49419	09
49420	01
49421	01
49422	01
49426	02
49495	04
49496	04
49500	04
49501	09
49505	04
49507	09
49520	07
49521	09
49525	04
49540	02

CPT Code	ASC Level
49550	05
49553	09
49555	05
49557	09
49560	04
49561	09
49565	04
49566	09
49568	07
49570	04
49572	09
49580	04
49582	09
49585	04
49587	09
49590	03
49600	04
49650	04
49651	07

3.9.8 Urinary System

CPT Code	ASC Level
50200	01
50390	01
50392	01
50393	01
50395	01
50396	01
50398	01
50542	09
50543	09
50551	01
50553	01
50555	01
50557	01
50559	01
50561	01
50562	01
50688	01
50947	09
50948	09
50951	01
50953	01
50955	01
50957	01
50959	01
50961	01
50970	01
50972	01
50974	01
50976	01
50978	01
50980	01
51010	01
51020	04
51030	04
51040	04
51045	04
51050	04

CPT Code	ASC Level
51065	04
51080	01
51500	04
51520	04
51710	01
51715	03
51726	01
51772	01
51785	01
51880	01
52000	01
52001	02
52005	02
52007	02
52010	02
52204	02
52214	02
52224	02
52234	02
52235	03
52240	03
52250	04
52260	02
52270	02
52275	02
52276	03
52277	02
52281	02
52282	09
52283	02
52285	02
52290	02
52300	02
52305	02
52310	02
52315	02
52317	01

CPT Code	ASC Level
52318	02
52320	05
52325	04
52327	02
52330	02
52332	02
52334	03
52341	03
52342	03
52343	03
52344	03
52345	03
52346	03
52351	03
52352	04
52353	04
52354	04
52355	04
52400	03
52450	03
52500	03
52510	03
52601	04
52606	01
52612	02
52614	01
52620	01
52630	02
52640	02
52647	09
52648	09
52700	02
53000	01
53010	01
53020	01
53040	02
53080	03

CPT Code	ASC Level
53200	01
53210	05
53215	05
53220	02
53230	02
53235	03
53240	02
53250	02
53260	02
53265	02
53270	02
53275	02
53400	03
53405	02
53410	02
53420	03
53425	02
53430	02
53431	02
53440	02
53442	01
53444	02
53445	01
53446	01
53447	01
53449	01
53450	01
53460	01
53502	02
53505	02
53510	02
53515	02
53520	02
53605	02
53665	01
53850	09

3.9.9 Male Genital System

CPT Code	ASC Level
54000	02
54001	02
54015	04
54057	01
54060	01
54065	01
54100	01
54105	01
54110	02
54111	02
54112	02
54115	01
54120	02
54150	01
54152	01
54160	02
54161	02
54162	02
54163	02
54164	02
54205	04
54220	01
54300	03
54304	03

CPT Code	ASC Level
54308	03
54312	03
54316	03
54318	03
54322	03
54324	03
54326	03
54328	03
54340	03
54344	03
54348	03
54352	03
54360	03
54380	03
54385	03
54400	03
54401	03
54405	03
54406	03
54408	03
54410	03
54415	03
54416	03
54420	04

CPT Code	ASC Level
54435	04
54440	04
54450	01
54500	01
54505	01
54512	02
54520	03
54522	03
54530	04
54550	04
54600	04
54620	03
54640	04
54670	03
54680	03
54690	09
54700	02
54800	01
54820	01
54830	03
54840	04
54860	03
54861	04
54900	04

CPT Code	ASC Level
54901	04
55040	03
55041	05
55060	04
55100	01
55110	02
55120	02
55150	01
55175	01
55180	02
55200	02
55250	02
55500	03
55520	04
55530	04
55535	04
55540	05
55550	09
55680	01
55700	02
55705	02
55720	01
55725	02
55859	09

3.9.10 Female Genital System

CPT Code	ASC Level
56440	02
56441	01
56515	03
56620	05
56625	07
56700	01
56720	01
56740	03
56800	03
56810	05
56820	01
56821	01
57000	01
57010	02
57020	02
57022	02
57023	01
57065	01
57105	02
57130	02
57135	02

CPT Code	ASC Level
57180	01
57200	01
57210	02
57220	03
57230	03
57240	05
57250	05
57260	05
57265	07
57268	03
57289	05
57291	05
57300	03
57400	02
57410	02
57415	02
57420	01
57421	01
57455	01
57456	01
57461	01

CPT Code	ASC Level
57513	02
57520	02
57530	03
57550	03
57556	05
57700	01
57720	03
57820	03
58120	02
58145	05
58350	03
58545	09
58546	09
58550	09
58553	09
58554	09
58555	01
58558	03
58559	02
58560	03
58561	03

CPT Code	ASC Level
58562	03
58600	04
58605	04
58615	04
58660	05
58661	05
58662	05
58670	03
58671	03
58672	05
58673	05
58800	03
58820	03
58900	03

3.9.11 Maternity Care and Delivery

CPT Code	ASC Level
59150	02
59151	02
59160	03
59320	01
59409	04
59812	05
59820	05
59821	05
59840	05
59841	05
59870	05
59871	05

3.9.12 Endocrine System

CPT Code	ASC Level
60000	01
60200	02
60280	04
60281	04

3.9.13 Nervous System

CPT Code	ASC Level
61020	01
61026	01
61050	01
61055	01
61070	01
61215	03
61790	03
61791	03
61885	02
61886	03
61888	01
62194	01
62225	01
62230	02
62252	01
62268	01
62269	01
62270	01
62272	01
62273	01
62280	01
62281	01
62282	01
62287	09
62294	03
62310	01
62311	01
62318	01
62319	01
62350	02
62355	02
62360	02
62361	02
62362	02
62365	02
63600	02

CPT Code	ASC Level
63610	01
63650	02
63660	01
63685	02
63688	01
63744	03
63746	02
64410	01
64415	01
64417	01
64420	01
64421	01
64430	01
64475	01
64476	01
64510	01
64520	01
64530	01
64553	01
64573	01
64575	01
64577	01
64580	01
64585	01
64590	02
64595	01
64600	01
64605	01
64610	01
64620	01
64622	01
64623	01
64630	02
64680	02
64702	01
64704	01

CPT Code	ASC Level
64708	02
64712	02
64713	02
64714	02
64716	03
64718	02
64719	02
64721	02
64722	01
64726	01
64727	01
64732	02
64734	02
64736	02
64738	02
64740	02
64742	02
64744	02
64746	02
64771	02
64772	02
64774	02
64776	03
64778	02
64782	03
64783	02
64784	03
64786	03
64787	02
64788	03
64790	03
64792	03
64795	02
64802	02
64821	04
64831	04

CPT Code	ASC Level
64832	01
64834	02
64835	03
64836	03
64837	01
64840	02
64856	02
64857	02
64858	02
64859	01
64861	03
64862	03
64864	03
64865	04
64870	04
64872	02
64874	03
64876	03
64885	02
64886	02
64890	02
64891	02
64892	02
64893	02
64895	03
64896	03
64897	03
64898	03
64901	02
64902	02
64905	02
64907	01

3.9.14 Eye and Ocular Adnexa

CPT Code	ASC Level
65091	03
65093	03
65101	03
65103	03
65105	04
65110	05
65112	07
65114	07
65130	03
65135	02
65140	03
65150	02
65155	03
65175	01
65235	02
65260	03
65265	04
65270	02
65272	02
65275	04
65280	04
65285	04
65290	03
65400	01
65410	02
65420	02
65426	05
65710	07
65730	07
65750	07
65755	07
65770	07
65772	04
65775	04
65800	01
65805	01
65810	03
65815	02
65850	04
65865	01
65870	04
65875	04
65880	04
65900	05
65920	07
65930	05
66020	01
66030	01
66130	07

CPT Code	ASC Level
66150	04
66155	04
66160	02
66165	04
66170	04
66172	04
66180	05
66185	02
66220	03
66225	04
66250	02
66500	01
66505	01
66600	03
66605	03
66625	03
66630	03
66635	03
66680	03
66682	02
66700	02
66710	02
66720	02
66740	02
66821	02
66825	04
66830	04
66840	04
66850	07
66852	04
66920	04
66930	05
66940	05
66982	08
66983	08
66984	08
66985	06
66986	06
67005	04
67010	04
67015	01
67025	01
67027	04
67030	01
67031	02
67036	04
67038	05
67039	07
67040	07

CPT Code	ASC Level
67107	05
67108	07
67110	05
67112	07
67115	02
67120	02
67121	02
67141	02
67210	01
67218	05
67227	01
67228	01
67250	03
67255	03
67311	03
67312	04
67314	04
67316	04
67318	04
67320	04
67331	04
67332	04
67334	04
67335	04
67340	04
67350	01
67400	03
67405	04
67412	05
67413	05
67415	01
67420	05
67430	05
67440	05
67450	05
67550	04
67560	02
67715	01
67808	02
67830	02
67835	02
67880	03
67882	03
67900	04
67901	05
67902	05
67903	04
67904	04
67906	05

CPT Code	ASC Level
67908	04
67909	04
67911	03
67914	03
67916	04
67917	04
67921	03
67923	04
67924	04
67935	02
67950	02
67961	03
67966	03
67971	03
67973	03
67974	03
67975	03
68115	02
68130	02
68320	04
68325	04
68326	04
68328	04
68330	04
68335	04
68340	04
68360	02
68362	02
68500	03
68505	03
68510	01
68520	03
68525	01
68530	01
68540	03
68550	03
68700	02
68720	04
68745	04
68750	04
68770	04
68810	01
68811	02
68815	02

3.9.15 Auditory System

CPT Code	ASC Level
69110	01
69120	02
69140	02
69145	02
69150	03
69205	01
69222	02
69300	03
69310	03
69320	07
69421	03
69436	03
69440	03
69450	01
69501	07
69502	07
69505	07

CPT Code	ASC Level
69511	07
69530	07
69550	05
69552	07
69601	07
69602	07
69603	07
69604	07
69605	07
69610	02
69620	02
69631	05
69632	05
69633	05
69635	07
69636	07
69637	07

CPT Code	ASC Level
69641	07
69642	07
69643	07
69644	07
69645	07
69646	07
69650	07
69660	05
69661	05
69662	05
69666	04
69667	04
69670	03
69676	03
69700	03
69711	01
69714	09

CPT Code	ASC Level
69715	09
69717	09
69718	09
69720	05
69725	05
69740	05
69745	05
69801	05
69802	07
69805	07
69806	07
69820	05
69840	05
69905	07
69910	07
69915	07
69930	07

3.9.16 Miscellaneous Codes

CPT Code	ASC Level
75901	01
75902	01
93580	09
93581	09
95990	01
96920	01
96921	01
96922	01

3.9.17 HCPCS ASC Level

HCPCS	ASC Level
G0105	02
G0121	02
G0256	09
G0260	01
G0261	09

3.10 Ambulance Service Policy

3.10.1 Overview

Hospital based ambulance service is payable only if used in the event of an emergency situation or after prior authorization has been obtained from the Department, Medicaid Transportation Unit (MTU) Medicaid Ambulance Review. Medicaid Ambulance Review manages ambulance transportation services, including prior authorization of non-emergency ambulance transportation and retrospective medical review of emergency ambulance claims.

Phone: (**208) 287-1155 or (800) 362-7648**
FAX: (**208) 334-5242 or (800) 359-2236**

3.10.1.1 Definition of Emergency Services

Medical necessity is established when the client's condition is of such severity that use of any other method of transport would endanger the client's life or health. An emergency exists when the severity of the medical situation is such that the usual prior authorization procedures are not possible because the client requires immediate medical attention.

3.10.1.2 Definition of Non-emergency Service

Medicaid defines non-emergency service as scheduled transportation provided when the physical condition of the client requires ambulance transport and another form of transportation will place the client's life or health in serious jeopardy. This includes interfacility transfers, nursing home to hospital transfers, and transfers to the client's home from the hospital.

Transportation of a client residing in a long-term care facility is the responsibility of the long-term care facility, unless the condition of the client requires ambulance transport and prior authorization has been obtained. If prior authorization is required, the prior authorization number must be included on the claim or the service will be denied.

3.10.2 Licensing Requirements

Ambulance services providers must hold a current license issued by the EMS Bureau (Emergency Medical Services) according to the level of training and expertise its personnel maintains, and must comply with the rules governing EMS services. Ambulance services providers based outside the state of Idaho must hold a current license issued by that state's EMS licensing authority. No payment will be made to ambulance services providers that do not hold a current license.

EMS Phone: (208) 334-4000

Fax: (208) 334-4015

3.10.3 Billing Information

Hospital based providers must bill on the UB-92 claim form using hospital revenue codes 540-549. See **Section 3.7.3** for more information on these revenue codes.

Both ground and air ambulance services owned and operated by hospitals must bill on the UB-92 using hospital revenue codes. UB-92 claim forms are

available from local form suppliers. These claims may also be submitted electronically by diskette or modem.

Required attachments include third party explanations of benefits (EOB) for other insurance payments and denials.

3.10.3.1 Third Party Recovery

Required attachments to UB92 claim forms include third party explanations of benefits (EOB) for other insurance payments and denials. If billing electronically, then the attachment is **not** required. However, the correct ARC codes and other insurance information must be submitted. See **Section 2** for information on Medicaid policy on billing all other third party resources before submitting claims to Medicaid.

3.10.3.2 Medicare Clients

If a client has Medicare coverage, the provider must first bill Medicare for services rendered. See **Section 2, Third Party Recovery, Crossover Claims**, for billing instructions.

3.10.3.3 Submit the Claim to EDS

Authorized claims are submitted to EDS for payment. The providers claim form must match the information on the *Notice of Decision* or claims will be denied.

3.10.4 Covered Services

3.10.4.1 Air Ambulance

Air ambulance services are covered when one of the following occurs:

- The point of pickup is inaccessible by a land vehicle.
- Great distances or other obstacles are involved in getting the client to the nearest appropriate facility and speedy admission is essential.
- The client's condition and other circumstances necessitate the use of air ambulance.
- If ground ambulance services would suffice and would be less costly, payment is based on the amount that would be paid for a ground ambulance.

Air ambulance must be approved by Medicaid Ambulance Review in advance except in emergency situations.

If the aircraft is owned and operated by a hospital, the service must be billed on a UB92 using appropriate revenue codes. Air ambulance services not owned by a hospital must bill on the CMS-1500 claim form, using HCPCS procedure codes.

3.10.4.2 Ground Ambulance

Ambulance services, which are owned and operated by a hospital, must be billed on the UB92 using hospital revenue codes. All other ambulance providers must submit claims on the CMS-1500 claim form using HCPCS procedure codes.

3.10.4.3 Waiting Time and Extra Attendants

Waiting time and extra attendants are not paid unless medically necessary, and authorized by Medicaid Ambulance Review. Waiting time must be physician-ordered.

3.10.4.4 Oxygen

Medicaid pays for oxygen when used by the client during transport. This rate includes disposables such as masks or cannulas.

3.10.4.5 Multiple Runs in One Day

When the ambulance has transported a client, returned to the base station, and transported the same client to another facility: two base rate charges will be allowed.

When the ambulance has transported a client, the same client is transferred to another facility, and the ambulance has not returned to the base station: one base rate will be allowed. Waiting time must be included in the base rate.

When the ambulance responds to a client's home for two emergencies in a single day and transports the client to the hospital twice: two base rates will be allowed. Indicate on the claim that there were multiple runs on the same day.

3.10.4.6 Round Trip

Medicaid allows round trip charges when a hospital inpatient goes to another hospital to obtain specialized services not available in the original hospital and the referral hospital is the nearest one with such facilities.

Medicaid places restrictions on round trip charges, depending on whether the ambulance returns to the base station between trips.

- When the ambulance does not return to base station, bill for one base rate, including waiting time, limited to one and one-half hours.
- When the ambulance does not wait but returns to the base station between trips, bill for two base rates.

Contact Medicaid Ambulance Review for questions about:

- Notice of Decision
- Reconsideration of decision
- Appeal process

(208) 287-1155
(800) 362-7648

3.10.4.7 Physician in Attendance

In some situations a physician in attendance will be justified. When a physician is in attendance, the documentation should justify the necessity and indicate the specialty type of the physician. Physicians are responsible for billing their own services.

3.10.4.8 Nursing Home Residents

Ambulance services are covered only in an emergency situation or when the requested service has been prior authorized by Medicaid Ambulance Review. Payment for any non-covered service is the responsibility of the facility.

3.10.4.9 Trips to Physician's Office

Ambulance service from a client's home to a physician's office is not covered unless it has been prior authorized by Medicaid Ambulance Review.

3.10.4.10 Treat and Release, and Respond and Evaluate

A treat and release payment may be authorized if the client is treated at the scene and not transported. Disposable supplies used at the scene are also

covered. Medicaid Ambulance Review may downgrade a claim to a non-emergency service if the client was transported but the transport has been determined not medically necessary.

A non-emergency service may be authorized if the ambulance responds to the scene and evaluates the client, but no treatment or transport is necessary. Medicaid Ambulance Review may also downgrade a claim to a non-emergency service if the client was transported but the transport has been determined not medically necessary.

3.10.4.11 Deceased Clients

Ambulance service for deceased clients is covered when documented in the run sheet as follows:

- If the client was pronounced dead after the ambulance was called but before pickup, a base rate will be allowed.
- If the client was pronounced dead while in route to or upon arrival at the hospital, a base rate and mileage will be allowed.
- If the client was pronounced dead by an authorized person before the ambulance was called, no payment will be made.

3.10.5 Reimbursement Information

3.10.5.1 Customary Fees

Medicaid reimburses hospital owned and operated ambulances on a cost basis and all other ambulance providers on a fee-for-service basis. Usual and customary fees are paid up to the Medicaid maximum allowance.

Transportation of nursing home clients is considered part of the content of nursing home care and therefore is the responsibility of the nursing home, unless the condition of the client requires ambulance transport. All non-emergency transports must be prior authorized by Medicaid Ambulance Review. For more information on prior authorizations, refer to **Section 3.10.6, Ambulance Service Prior Authorization.**

See **Section 2** for information on crossover claims.

3.10.5.2 Base Rate for Ambulances

Levels of Service

There are three levels of service that providers may request when seeking reimbursement for patient transports, and treat and release (non transport):

- Non-Emergency services, including Treat and Release or Respond and Evaluate
- Emergency services
- Neonatal ambulance services

When reviewing and authorizing a particular level of service Medicaid Ambulance Review must consider if:

- an emergency existed; or
- the transport, or services rendered if the patient was not transported, was medically necessary

Services must correspond with the Idaho Administrative Code acts and duties allowed for the Prehospital Care Providers, as per IDAPA 16.02.03.205.

Separate fees are allowed for supplies, oxygen, pharmacy items, and EKG (see section 3.7.3 for revenue codes 540-549). Mileage must be included in the base rate.

3.10.6 Ambulance Service Prior Authorization

Medicaid Ambulance Review operates a transportation management system for medical transportation services. This includes prior authorization of non-emergency ambulance and the retrospective medical review of emergency transport by ambulance. Any Medicaid claim for ambulance services must include an authorization number from Medicaid Ambulance Review when submitted to EDS for payment.

Phone: **(208) 287-1155 or (800) 362-7648**
Fax: **(800) 359-2236 or (208) 334-5242**

3.10.6.1 Nonemergency Ambulance Transportation

If non-emergency transport by ambulance is medically necessary, Medicaid Ambulance Review issues a prior authorization (PA) number.

Hospital-based ambulances must include the PA number in field 63 of the UB92 form and bill on an outpatient claim and in the appropriate field on the electronic form. Run sheets are not required when the claim is submitted to EDS.

3.10.6.2 Emergency Transportation

Fax or mail notice of emergency and non-emergency transports to Medicaid Ambulance Review at:

Fax (208) 334-5242 or (800) 359-2236

Division of Medicaid
Medicaid Ambulance Review
P.O. Box 83720
Boise, ID 83720-0036

3.10.7 Requests for Retrospective Review/Authorization

To obtain a retrospective authorization for emergency services and/or transportation, fax or mail a copy of the completed claim form and patient care record to Medicaid Ambulance Review. Attach a copy of the third party explanation of benefits (EOB) if applicable

Upon receipt of the completed claim information:

- The appropriateness of the revenue code billed is evaluated and may be downgraded to a non-emergency service.
- The claim is evaluated for appropriate treatment and disposable supply codes as requested. All requested supplies and treatment must be medically appropriate for the medical condition supported by the patient care record.
- Any potential denial or downgrade of the requested service is referred to an on-call emergency medicine physician for review prior to the denial or downgrade.

Contact Medicaid Ambulance Review at:

(208) 287-1155 (Boise calling area)

(800) 362-7648 (toll free)

An approved or denied decision is submitted to EDS and a *Notice of Decision* is generated to the client and the ambulance provider. The *Notice of Decision* will include any Prior Authorization (PA) numbers, procedure codes, dates of service, and number of units necessary for billing. Questions regarding *Notice of Decision* should be directed to Medicaid Ambulance Review.

3.10.6.2 Submitting Requests for Retrospective Review/Authorization

Phone: **(208) 287-1155 or (800) 362-7648**
Fax: **(208) 334-5242 or (800) 359-2236**

Division of Medicaid
Medicaid Ambulance Review
P.O. Box 83720
Boise, ID 83720-0036

3.10.7 Requests For Reconsideration (Appeals)

Providers may appeal a prior authorization (PA) decision made by the Department, Medicaid Transportation Unit, *Medicaid Ambulance Review* by following these steps:

Step 1 Carefully examine the *Notice of Decision for Medical Benefits* to ensure that the service(s) and requested procedure code was actually denied. Occasionally a requested service/procedure code has been denied and the appropriate service/procedure code was actually approved on the next line in the notice. If the provider determines that an inappropriate denial of service has occurred, the next step is to submit a written *Request for Reconsideration*.

Step 2 Prepare a written *Request for Reconsideration*, which includes any **additional** or extenuating circumstances and **specific** information that will assist the authorizing agent in the reconsideration review.

Step 3 Submit the written request directly to Medicaid Ambulance Review within 35 days of the date on the *Notice of Decision for Medical Benefits*.

Mail the *Request for Reconsideration* to:
Division of Medicaid
Medicaid Ambulance Review
P.O. Box 83720
Boise, ID 83720-0036

Step 4 Medicaid Ambulance Review will return a second *Notice of Decision for Medical Benefits* to the requestor within 30 days of receipt of the provider's *Request for Reconsideration*. If the **reconsidered** decision is still contested by the provider, the provider may then submit a written request for an appeal of the reconsideration review decision directly to the Department of Health and Welfare.

3.10.8 Requests For Reconsideration (Appeals) of Medicaid Ambulance Review

To submit a written request for an appeal of the *Medicaid Ambulance Review* decision, follow the steps below. Providers may fax all documentation but the fax must be followed with copies of original documents in the mail.

Step 1 Prepare a written request for an appeal that includes:

- a copy of the Notice of Decision For Medical Benefits from Medicaid Ambulance Review
- a copy of the Request for Reconsideration from the provider
- a copy of the second Notice of Decision for Medical Benefits from Medicaid Ambulance Review showing that the request for reconsideration was performed
- an explanation of why the reconsideration remains contested by the provider
- copies of all supporting documentation

Step 2 Mail the information to:

Hearings Coordinator
Idaho Department of Health & Welfare
Administrative Procedures Section
P.O. Box 83720
Boise, ID 83720-0036

3.11 Diabetes Education and Training

Medicaid covers individual and group counseling for diabetes education and training. These outpatient services are limited to clients and providers who meet the criteria specifically identified in the Rules Governing Medical Assistance (IDAPA 16.03.09.128.). Providers must operate an American Diabetes Association (ADA) Recognized Diabetes Education Program to provide group diabetes counseling/training. Only Certified Diabetes Educators (CDE) may provide individual counseling through a recognized program, a physician's office, or outpatient hospital counseling. Their counseling services must be billed under the provider number of their employer, i.e., the hospital, or physician's clinic provider number.

3.11.1 Individual Counseling-Diabetes/Education Training

For reimbursement, bill with procedure code **G0108** (in one-hour increments), in conjunction with Revenue Code **942** to comply with Medicare billing instructions. The CDE's services are to augment and not be substituted for the services a physician is expected to provide to diabetic clients. Medicaid allows only twelve (12) hours per client every five (5) years for individual counseling.

3.11.2 Group Counseling-Diabetes Education/Training

For reimbursement, bill with procedure code **G0109** (one-hour increments), in conjunction with Revenue Code **942** to comply with Medicare billing instructions. Only hospitals operating an ADA Recognized Program may bill for group counseling. Medicaid allows only twenty-four (24) hours per client every five (5) years for group counseling.

3.12 Dietitian Service Policy

3.12.1 Overview

Dieticians may bill the Medicaid program directly for nutritional services provided to pregnant women and children. Nutritional services include intensive nutritional education, counseling, and monitoring. Either a registered dietician must render these services **or** an individual who has a baccalaureate degree granted by a U.S. regionally accredited college or university and has met the academic and professional requirements in dietetics as approved by the American Dietetic Association. If a dietician works for a hospital, the hospital bills Medicaid directly for the services.

3.12.2 Covered Services

3.12.2.1 PWC Services

Nutritional services for women enrolled in the PWC (Pregnant Women and Children) program. All listed criteria must be met:

- Must be ordered by the patient's physician, nurse practitioner or nurse midwife.
- Must be delivered after confirmation of pregnancy.

Extend only through the 60th day after delivery.

3.12.2.2 EPSDT Services

EPSDT benefits are for children through the month of their twenty-first (21)birthday. All criteria listed must be met:

- Must be discovered by an EPSDT screen
- Ordered by a physician
- Determined to be medically necessary
- Determined to not be due to obesity

3.12.3 Limitations

NOTE
If a dietitian works for a hospital, then the hospital bills directly for this service.

3.12.3.1 PWC

Payment for two (2) visits during the calendar year is available at a rate established under the provisions of Subsection 03.09.060.04. If a dietitian works for a hospital, then the hospital bills directly for this service.

3.12.3.2 EPSDT

Payment for two (2) visits during the calendar year is available at a rate established under the provisions of Subsection 03.09.060.04.

Children may receive two (2) additional visits when prior authorized by the EPSDT Coordinator. Submit prior authorization request to the following address: Idaho Medicaid, Bureau of Care Management, Attn: EPSDT Coordinator, PO Box 83720, Boise, Idaho 83720-0036.

3.12.4 Procedure Codes

Service	Code	Modifier	Description
PWC Nutritional Services	S9470	**U5**	Nutritional Counseling, dietician visit *The **U5** (PWC) modifier is required when reporting dietician services for the PWC Program*
EPSDT Nutritional Services	S9470	No modifier required	Nutritional Counseling, dietician visit

3.13 Claim Billing

3.13.1 Which Claim Form to Use

Claims that do not require attachments may be billed electronically using PES software (provided by EDS at no cost) or other HIPAA compliant vendor software.

To submit electronic claims, use the HIPAA-compliant 837 transaction.

To submit claims on paper, use original red UB-92 claim forms available from local form suppliers.

3.13.2 Electronic Claims

See **Section 2** for more information on electronic billing.

For PES software billing questions, consult the *Idaho PES Handbook*. Providers using vendor software or a clearinghouse should consult the user manual that comes with their software.

In addition to new HIPAA-required fields, the changes listed in ***Guidelines for Electronic Claims*** are effective October 20, 2003.

3.13.2.1 Guidelines for Electronic Claims

Detail lines
Idaho Medicaid allows up to 999 detail lines for electronic HIPAA 837 Institutional claims.

Surgical procedure codes
Idaho Medicaid allows **25** surgical procedure codes on an electronic HIPAA 837 Institutional claim.

Four modifiers
On an electronic HIPAA 837 Institutional claim, where revenue codes require a corresponding HCPCS or CPT code, up to 4 modifiers are allowed. (On a paper claim, only 2 modifiers are accepted.)

Revenue codes, which are broken into professional and technical components, require the appropriate modifier. For institutional claims, the TC modifier must be submitted.

Type of bill (TOB) codes
Idaho Medicaid rejects all electronic transactions with TOB codes ending in a value of 6. Electronic HIPAA 837 claims with valid type of bill codes not covered by Idaho Medicaid are rejected before processing.

Condition codes
Idaho Medicaid allows 24 condition codes on an electronic HIPAA 837 Institutional claim.

Value, occurrence, and occurrence span codes
Idaho Medicaid allows **24** value, **24** occurrence, and **24** occurrence span codes on the electronic HIPAA 837 Institutional claim.

Diagnosis codes
Idaho Medicaid allows **27** diagnosis codes on the electronic HIPAA 837 Institutional claim.

Ambulance services
Idaho requires the following information when submitting an electronic HIPAA 837 Institutional claim for ambulance services.

- Transport Code
- Transport Reason Code
- Transport Distance
- Condition Code
- Round Trip Purpose when the transport code is equal to X for round trip.

National Drug Code (NDC) information with HCPCS and CPT codes
A corresponding NDC is required to be indicated on the claim detail when drug related HCPCS or CPT codes are submitted.

Electronic crossovers
Idaho Medicaid allows providers to submit electronic crossover claims for Institutional services.

3.13.3 Guidelines for Paper Claim Forms

3.13.3.1 How to Complete the Paper Claim Form

The following will speed claim processing:

See **Section 3.13.3.4**, for instructions on completing specific fields.

- Complete all required areas of the claim form.
- Print legibly using black ink or use a typewriter.
- When using a printer, make sure the form is lined up correctly to facilitate electronic scanning.
- Keep claim form clean. Use correction tape to cover errors.
- A maximum of 23 line items per claim can be accepted. If the number of services performed exceeds 23 lines, prepare a new claim form and complete the required data elements. Total each claim separately.
- Be sure to sign the form in the correct field. Claims will be denied that are not signed.
- Do not use staples or paperclips for attachments. Stack them behind the claim.
- Do not fold the claim form(s). Mail flat in a large envelope (recommend 9 x 12).

3.13.3.2 Where To Mail the Paper Claim Form

Send completed claim forms to:

EDS
P.O. Box 23
Boise, ID 83707

3.13.3.3 Completing Specific Fields on a Paper Claim Form

Refer to 3.13.3.5, Sample Claim Form, to see a sample UB-92 claim with all fields numbered. Provider questions regarding hospice policy and coverage requirements are referred to the Rules Governing Medical Assistance.

The following numbered items correspond to the UB-92 claim form. Consult the Use column to determine if information in any particular field is required and refer to the Description column for additional information. Claim processing will be interrupted when required information is not entered into any required field.

Field	Field Name	Use	Description
1	Unlabeled field	Required	Provider Name, Address, and Telephone Number: Enter the provider name, address, and telephone number. The first line on the claim form must be the same as the first line of the RA. Note: If there has been a change of name, address, phone number, or ownership, immediately notify Provider Enrollment, in writing, to update the Provider Master File.
4	TYPE OF BILL	Required	Type of Bill: Enter the three-digit code from the UB92 manual. Adjustment type-of-bill codes are not appropriate for Idaho Medicaid billings. See **Section 3.1.7** for Type of Bill codes.
6 **A & B**	STATEMENT COVERS PERIOD	Required	Statement Covers Period From/Through: The beginning and ending service dates of the period included on the bill. **Administratively Necessary (AN) Days:** The from date is the month, day, and year the client was discharged from inpatient acute level of care. **Outpatient Claims**: Outpatient claims must indicate the specific dates in **Field 45** to eliminate duplicate appearing services. **Late or Additional Charges:** **Inpatient** claims - see field 42 for information. **Outpatient** claims - see field 45 for information. **Accommodation Charges:** Medicaid does not pay accommodation charges, or any fraction thereof, for the last day of hospital room occupancy when a client is discharged under normal circumstances. Although there is no reimbursement for the discharge day, that date should always be entered on the claim form. This ensures that the hospital receives reimbursement for the last full day of accommodation. **Extended Hospitalization:** If a client requires extended hospitalization and the hospital decides to send an interim claim, enter patient status code **30** in **Field 22**. This code tells the system that the client is still a patient and to reimburse the hospital for the last day on the claim. ***Example:*** Claims for three sequential interim bills would have the following sequential date and patient status format: **Patient Days** **Claim / From / To Date / Status / Billed** 1 / 01/15-01/31/04 / 30 / 17 2 / 02/01-02/15/04 / 30 / 15 3 / 02/16-02/24/04 / 01 / 8 ***NOTE*:** If patient status 30 is not used, the accommodation rate formula will not balance and the system will deny the claim.
7	COV D	Required	Covered Days: Required for inpatient claims only

Field	Field Name	Use	Description
12	PATIENT NAME	Required	Patient Name: Enter the client's name exactly as it is spelled on the client's MAID card. Be sure to enter the last name first, followed by the first name and middle initial.
19	ADMISSION TYPE	Required Inpatient	Admission Type: Use the priority admission codes in the UB92 manual. Only codes 1, 2, 3, and 4 are allowed by Medicaid. **Required** for inpatient claims.
20	ADMISSION SRC.	Required Inpatient	Admission Source: Use the one-digit source of admission codes 1 through 8 in the UB92 manual. Medicaid does not accept code 9. **Required** for inpatient claims **Not Required** for outpatient claims.
21	D HR.	Required Inpatient	Discharge Hour: Enter the two-digit hour the client was discharged in military time. **Examples:** Enter 01 for 1:00 a.m. Enter 10 for 10:00 a.m. Enter 22 for 10:00 p.m. **Required** for inpatient claims **Desired** for outpatient claims
22	STAT	Required Inpatient	Patient Status: Use one of the codes listed in **Section 3.1.9, Patient Status Codes**, to indicate patient status. **Required** for inpatient claims **Not Required** for outpatient claims.
23	MEDICAL RECORD NO.	Desired	Medical/Health Record Number: The number assigned to the client's medical/health record.
39-41	VALUE CODES / AMOUNTS	Required: AN Days	Value Codes and Amounts: See **Section 3.5.4**, Billing Procedures, for directions on how to bill administratively necessary days (AND).
42	REV. CD.	Required Inpatient	Revenue Codes: All revenues codes are accepted by Idaho Medicaid, however, not all codes are payable. Use revenue code 001 for a total line and enter the claim's total in field 47. **Inpatient claims (late, additional, or denied charges):** 1. Late or additional charges where the revenue code was **not** on the original claim: bill on a new claim for only the late or additional charges with the accommodation rate and revenue code**.** Note in the Field 84, *"Billing for late charges."* 2. Late or additional charges where the revenue code was paid on the original claim: submit an adjustment request form with the corrected information. 3. Bill for denied line(s) from the original claim: bill the denied line with the accommodation rate and revenue code on a new claim. Note in the Field 84, *"Billing for denied lines."* **Outpatient claims (late, additional, or denied charges):** For instructions for outpatients billing refer to Field 45.
44	HCPCS/RATES	Required If Applicable	CPT/HCPCS/MODIFIERS/RATES: All accommodation codes require dollar amounts. CPT/HCPCS are required for all revenue codes with CPT or HCPCS notation in **Section 3.5.5 Revenue Codes** and **Section 3.7.3 Ancillary Revenue Codes**. If the code requires a modifier, put one space between the code and modifier. For example, PET scans require a HCPCS code and the TC modifier. (i.e. G0222 TC)

Field	Field Name	Use	Description
45	SERV. DATE	Required Outpatient	Service Dates: Required for all outpatient services. Enter the specific date of service for all charges Claims are denied when the specific dates are not entered in this field. **Outpatient claims (late, additional, or denied charges):** 1. Late or additional charges **outside** the date span in Field 6: bill on a new claim form. Note in the Field 84, *"Billing for late charges."* 2. Late or additional charges **within** the date span in Field 6 with the **same** revenue codes and the **same** specific date: submit on an adjustment request form. 3. Late or additional charges **within** the date span in Field 6 with **different** revenue codes: bill on a new claim form. Note in the Field 84, *"Billing for late charges."* 4. Resubmit all denied charges on a new claim.
46	SERV. UNITS	Required	Units of Service: Enter the total number of covered accommodation days or ancillary units of service. Units of service for accommodations must correlate accurately to the service rendered. ***Example:*** Accommodation Code = Number of days the level of service was rendered. ***NOTE*:** It is important to put the most appropriate rate next to the related code. Do not average charges for the same code. If a client in the hospital receives three different levels of care, each must be billed on a separate line. ***Example:*** Level I = $100 x 3 units of service Level II = $150 x 2 units of service Level III = $200 x 1 unit of service
47	TOTAL CHARGES	Required	Total charges: Bill total covered charges only. Ancillary Charges Formula: Revenue Code Fee X Units of Service Total Charges Accommodation Rate Formula: Daily Rate X Units of Service Total Charges
In Fields 50 through 62, each field has three lines: A, B, and C. If Medicaid is the only payer, enter all Medicaid data on line A. If there is one other payer in addition to Medicaid, enter all primary payer date on line A and all Medicaid data on line B. If there are two other payers in addition to Medicaid, enter all primary payer data on line A, all secondary payer date on line B, and all Medicaid data on line C.			
50 A	PAYER	Not required	Payer A: **If** Medicaid is the only payer, enter "Idaho Medicaid" in Field 50A. **If** there is one other payer in addition to Medicaid, enter the name of the group or plan in **field 50A** and enter *"Idaho Medicaid"* in **Field 50B**.
50 B	PAYER	Not required	Payer B: If there are two other payers in addition to Medicaid, enter the names of the group or plan in **Fields 50A** and **50B** and enter *"Idaho Medicaid"* in **Field 50C**.
50 C	PAYER	Not required	Payer C: If there are two other payers in addition to Medicaid, enter *"Idaho Medicaid"* in **Field 50C**.

Field	Field Name	Use	Description
51 A-C	PROVIDER NO.	Required	Provider number: Enter the nine-digit Idaho Medicaid provider number on the same line that Medicaid is shown as the payer. Enter the appropriate provider number for other insurance on the same line as that insurance is listed in 50 A-C. ***Example:*** in Field 50A, Medicare is entered as the Payer. In Field 51A, enter the identification number used by Medicare for the provider. ***Example:*** in Field 50B, Healthy Home Insurance Company is entered as the Payer. In Field 51B enter the identification number used by Healthy Home Insurance Company for the provider.
54	PRIOR PAYMENTS	Required If Applicable	Prior Payments — Payers and Client: **Required** if other insurance has paid. Enter the amount the hospital has received toward the payment of this hospital bill from another payer. Do **not** include payment from Medicare or previous Medicaid payments.
55	EST. AMOUNT DUE	Not required	Estimated Amount Due: Total charges due (total from **Field 47**) minus prior payments (total from **Field 54**).
58	INSURED'S NAME	Desired	Insured's Name: If the client's name is entered, be sure it is exactly as each payer uses it. For Medicaid, enter the name as it appears on the client MAID card. Be sure to enter the last name first, followed by the first name and middle initial.
59	P. REL	Desired	Patient's Relationship to Insured: See the UB-92 Manual for the two-digit relationship codes.
60	CERT.-SSN-HIC. ID NO,	Required	Client Identification Number: Enter the seven-digit MID number exactly as it is given in the Eligibility Verification System in this field. If your computer system demands an 11-digit MID, zero fill the eighth through the eleventh digits. ***Example:*** 0234567 can be entered as 02345670000. Enter the identification number used by other payers on the appropriate line(s).
61	GROUP NAME	Not required	Insured Group Name: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
62	INSURANCE GROUP NO.	Not required	Insurance Group Number: If used, Medicaid requires the primary payer information on the primary/secondary payer line when Medicaid is secondary/tertiary.
63	TREATMENT AUTHORI-ZATION CODES	Required If Applicable	Treatment Authorization Codes: prior authorization number for administratively necessary days or retrospective reviews or prior authorization number for ambulance run by EMS.
67	PRIN. DIAG. CD.	Required	Principal Diagnosis Code: Enter the ICD-9-CM code for the principal diagnosis. Do **not** use "E" diagnosis codes.
68-75	OTHER DIAG. CODES	Desired	Other Diagnosis Codes: Use the ICD-9-CM code(s) describing the secondary diagnoses. Do **not** use "E" diagnosis codes.
76	ADM. DIAG. CD.	Required	Admitting Diagnosis Code: **Required** for inpatient. **Desired** for outpatient claims. Peer Review Organization (PRO) has designated specific V codes that are not appropriate as admitting diagnoses. Consult the PRO-West Provider Manual.

Field	Field Name	Use	Description
77	E-CODE	Desired	External Cause of Injury Code: Enter the ICD-9-CM code for the external cause of an injury, poisoning or adverse effect. This code is to be used in addition to the principal diagnosis code and not instead of. (E codes are not used on the HCFA 1500 claim form for professional claims.)
80	PRINCIPAL PROCEDURE CODE / DATE	Desired	Principal Procedure Code and Date: Enter the ICD-9-CM code identifying the principal surgical or obstetrical procedure. Procedure date is required if procedure code is used.
81 A-E	OTHER PROCEDURE CODE / DATE	Desired	Other Procedure Codes and Dates: Enter all secondary surgical or obstetrical procedures. ICD-9-CM coding method should be utilized. Procedure date is required if procedure code is used.
82	ATTENDING PHYS. ID	Required	Attending Physician Identification Number: **Inpatient** — Enter the Idaho Medicaid Provider number for the physician attending an inpatient. This is the physician primarily responsible for the care of the client from the beginning of this hospitalization. **Outpatient** — Enter the Idaho Medicaid Provider number for the physician referring the client to the hospital.
83A-B	OTHER PHYS. ID	Required Healthy Connection	Other Physician Identification Number: **Required** for Healthy Connections clients referred to the hospital by the primary care provider. Enter the primary care provider's 9-digit numerical referral number in field 83A. Do not include the letters "HC" before the number.
84	REMARKS	Not required	Remarks: Enter information when applicable. For clients who have only Medicare Part A, enter *"Client has Part A only."* Other information to be entered may include: timely proof, ICN, retro-eligibility, or no TPC.
85	PROVIDER RE-PRESENTATIVE	Required	Provider Representative Signature: Signature of the hospital's authorized agent or signature on record. The claim will be returned if it is not signed.
86	DATE	Required	Date Bill Submitted

3.13.3.4 Sample Paper Claim Form